WATH-UPON-DEARNE
URBAN DISTRICT COUNCIL

ANNUAL REPORTS

OF THE

MEDICAL OFFICER OF HEALTH

AND THE

SANITARY INSPECTOR

FOR

1949

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WATH-UPON-DEARNE URBAN DISTRICT COUNCIL

MEMBERS 1949

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*Resigned. †Elected.

Medical Officer of Health :

ANTHONY EUSTACE, M.B., Ch.B., B.A.O., L.M., B.Sc., D.P.H.

Sanitary Inspector :

W. W. WILKINSON, M.S.I.A., Cert.S.I.B.

WATH-UPON-DEARNE URBAN DISTRICT COUNCIL

Annual Report of the Medical Officer of Health

for the year 1949.

Public Health Department,

Dunford House,

Doncaster Road,

Wath-upon-Dearne.

To the Chairman and Members of the
Wath-upon-Dearne Urban District Council.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present to you the Annual Report on the Health of the District and the Divisional Area for the year 1949. The National Health Service Act has now been in operation for 2 years but there are yet many difficulties to overcome. I am pleased to report that during the year under review a close relationship has come to exist between the Practitioners and Hospital Staffs, who serve the Divisional Area, and the Health Department. It is my aim to try and ensure that full use is made of the Personal Health Services now available. These services include the provision of Home Helps, Home Nursing and Health Visiting, Domiciliary Midwifery—including Gas and Air Analgesia in childbirth, admission to Convalescent Homes, schemes for the care of the infant or the special arrangements for the care of the Premature Baby in the home. Close co-operation exists between the Health, the Welfare, and Mental Health Departments of the County, and this enables us to make arrangements for the accommodation and care of the aged, and also of children whose parents have to enter Hospitals or Sanatoria. It also enables us to make suitable provision for the specialised care necessary for those members of our community whoare handicapped including those suffering from Mental Diseases. There is yet much progress to be made in fully integrating the Local Sanitary with the Major Health Authority. Preventive medicine is no longer concerned only with the purification of water supplies, the disposal of sewage, street cleansing, the abatement of overcrowding and nuisances and the control of the Infectious Diseases. Custom has now placed water undertakings and sewage disposal under the control of water engineers and the routine abatement of nuisances and

housing defects is now primarily the concern of the Sanitary Inspector. The broader concept of Preventive Medicine embraces all aspects of community health and well being, as is instanced by the Personal Health Services. It has to do with Mental Health as well as physical health. It has to link curative with preventive medicine. In broad outline it aims towards the establishment of a regime where disease has been conquered and where mental contentment reigns ; where the worker is in concord with his occupation and where his housing and economic needs are satisfactory. There is always the danger that in the nationalization of medicine the machinery might become master of the man. We must guard against indiscriminate encroachment into the family life—we must still respect the parents intrinsic rights over their children and themselves, and above all, we must not allow this social welfare scheme to become an Imponderable and Impersonal Giant. The unit of a great state is the healthy happy family. We should use every means in our power to foster this concept of sane living. We are not the judges of morals but we have the material means to help in the establishment of happy family life in our community. Our first priority should be housing; and initial emphasis should be on slum clearance and the rehousing of all persons living in sub-standard property. Guidance should be freely given to those members of our population who are for one reason or another unable to adjust their lives to, or accept the tempo of, the normal standards of society. These constitute, in fact, our so-called "problem families"—and it is our help they need more than anything else. There is scope here for the setting up of local voluntary advisory committees composed of members who would be activated by the highest motives, possess the milk of human kindness, be approachable and understanding, and willing to *actively* participate in the rehabilitation of the problem family.

The spate of legislation covering the social services has assumed tremendous proportions during the last 5 years. The lay person is apt to become bewildered and is unable to sort things out for himself. In his daily life he has to do with the National Health Service Act, the National Assistance Act, The National Insurance Act and the various Welfare and other services. The number of enquiries which are received from people at the Divisional Health Offices has increased considerably and it may well be that the time has come to consider seriously the inauguration of a centrally situated "Enquiry Bureau" to give information, advice and help to those who need it.

The formation of a Divisional Health Committee, with recognized delegated functions is in my opinion desirable in order that the development and progress of the County Services within the Divisional area, could be discussed ; such a committee would be invaluable in dealing with local difficulties and initiating the means to overcome them. The Committee would also go a long way towards creating fellow feeling between the Urban District Councils in the Division and would tend to bring the Local Sanitary Authority, and possibly the Area Management Committee of the Regional Hospital Board, and the Medical Committee of the Executive Council together.

Among the many matters advanced during the year one or two are worthy of specific mention. In dealing with Infectious Diseases the

Health Visitors have been brought more into the picture. When a notification of an infectious disease of a pre-school or school child is received at the office, the Health Visitor is automatically sent to pay a visit to the infected household. In the case of babies and pre-school children she is instructed to keep in touch with the patient and the parents and the family doctor if necessary, until the child has recovered. She is also instructed to advise the parents as to isolation, precautionary measures to be taken for the other members of the household, etc. This is in addition to the routine enquiry carried out by the Sanitary Inspector.

Another advance during the year has been the introduction of a scheme to link up the Hospitals serving the area with the Health Department and with the General Practitioner. Briefly the scheme operates as follows: Where a patient is due for discharge from Hospital, arrangements are made for after care to be provided by the midwives, home nurses or health visitors on the Divisional Staff. This care is in addition to that provided by the family doctor. If necessary, special equipment is loaned out to the patient, e.g., bed rests, wheel chairs, Dunlopillo mattresses, etc. In addition the Local Authority appraises the Hospital if home conditions are not suitable for discharge of the patient and this may lead to the patient being sent to a convalescent home until recuperated, rather than being sent home to overcrowded or unsuitable conditions which might militate against recovery.

The following statistics are given for the year under review (the left hand column indicates this year's rate ; the middle column last year's rate, and the right hand column the rate for England and Wales for 1949) :

Table A.

	1949	1948	1949 (Eng. & Wales)
Live Birth rate	17.99	19.70	16.7
Still Birth rate	0.43	0.36	0.39
Death rate (Crude) ..	11.53	11.34	11.7
*Death rate (adjusted) ..	12.56	—	—
Infant Mortality rate ..	60.48	62.96	32.0
Maternal Mortality rate ..	Nil	Nil	Nil
Neo-Natal Death Rate ..	24.15	51.85	—

A decrease in the birth rate is again noticeable but it is nevertheless greater than that for the country as a whole. There were 248 live births as compared with 270 in 1948. There were in addition six (6) still births compared with five (5) last year. Of the total live births sixteen (16) were illegitimate, an increase of five (5) over last year's figure.

There was a total of 159 deaths in 1949 compared with 155 in 1948.

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*The death rate was higher than last year being 11·53, it was however, less than that of the country as a whole. The adjusted Death Rate was 12·56. The adjusted Death Rate takes into account the sex and age distribution of the population and the Registrar-General assigns to each area a "comparability factor." If the crude death rate be multiplied by this factor the resultant rate enables a true comparison to be made with the death rates of other districts.

Births exceeded deaths by 89 and this figure represents the natural increase in your population.

The Infant Mortality Rate is high, but is nevertheless below that of last year. In all 15 infants died in the first year of life and six of these before reaching the age of one month. Further comment on Infant Mortality will be found in the Divisional Report.

There were no Maternal Deaths during the year.

Of the Infectious Diseases, Measles was widespread, and there were 257 cases notified. Only one death occurred and this was due to Pneumonia complicating the disease. Further comment on the infectious diseases is contained in the report.

No case of Acute Anterior Poliomyelitis occurred in the district during the year.

In conclusion, I wish to take the opportunity of thanking the Chairman and Members of the Public Health Committee for their interest in the Department during the year, and I also wish to thank the officials for there help during the year. The loyalty and enthusiasm of the Divisional Nursing and Clerical staff is worthy of the highest commendation, each and every one of whom have contributed, in no small measure, during the year to the development of the Health Services.

I remain,

Your obedient Servant,

ANTHONY EUSTACE.

NATURAL AND SOCIAL CONDITIONS OF THE AREA

Wath-upon-Dearne.

Area (in acres)	2,665
Population (Census 1931)	13,655
Registrar-General's estimate of Resident Population, mid 1949	13,780
Number of inhabited houses (Census 1931)	3,375
Number of inhabited houses (31st Dec., 1949)	4,092
Net Product of a Penny Rate	£220 13s. 8d.
Height above Sea Level	70—325 ft.
Rainfall for Year	21·36
Rateable Value	£52,964 0s. 0d.

VITAL STATISTICS (Provisional).

		Males.	Females.	Total.
Live Births :	Legitimate	114	118	232
	Illegitimate	9	7	16
Stillbirths :	Legitimate	3	3	6
	Illegitimate	—	—	—
Deaths of Infants under 1 year :				
	Legitimate	6	9	15
	Illegitimate	—	—	—
Deaths (all ages)		75	84	159

Birth Rate per 1,000 of the estimated resident population	17.99
Stillbirths—Rate per 1,000 total births (live and still)	23.62
Death Rate per 1,000 estimated population :	
Crude	11.53
Adjusted	12.56

(Comparability factor—1.09).

Deaths from Puerperal Causes :

	Deaths.	Death rate per 1,000 total (live and still) Births.
Puerperal and post-abortive sepsis	—	—
Other maternal causes	—	—

Death Rate of Infants under One Year of Age :

All infants per 1,000 live births	60.48
Legitimate infants per 1,000 legitimate live births	64.65
Illegitimate infants per 1,000 illegitimate live births	Nil
Neo-Natal Death Rate	24.15

Deaths from :	Cancer (all ages)	17
	Measles (all ages)	1
	Whooping Cough (all ages)	1
	Diarrhoea (under 2 years of age)	3
	Pulmonary Tuberculosis (all ages)	3
	Other forms of Tuberculosis (all ages)	—

GENERAL PROVISION OF HEALTH SERVICES.

1.—Hospitals.

Wath-upon-Dearne is in the Sheffield Regional Hospital Board area. In particular it is served by the Rotherham and Mexborough Hospital Management Committee. The Urban District Council has no representative on the Management Committee. The following Hospitals provide General and Surgical Service :—

(*a*) Moorgate General Hospital, Rotherham.

(*b*) Doncaster Gate General Hospital, Rotherham.

(*c*) Montagu Hospital, Mexborough.

(*a*) General Hospitals at Sheffield are also accessible and their services are used to some extent. Patients are very often referred from any of the above hospitals to some of the specialist hospitals in Sheffield.
(*b*) *Infectious Diseases Hospitals.*

The Wath Wood Isolation Hospital (110) beds provides accommodation for cases of Infectious Diseases which occur in the Urban District. It is a nicely situated hospital overlooking Hoober and has a modern cubicle block. Your former Medical Officer of Health was Medical Superintendent of this Hospital, but with the advent of the National Health Service Act, it is now proposed to appoint Dr. Morrison of the Rotherham Fever Hospital as Superintendent. Up to this the Hospital had its limitations—not being a Training School for fever nurses. Cases of smallpox are now admitted to only three hospitals in the Sheffield Region and cases from Wath-on-Dearne would normally be admitted to Lodgemoor Hospital at Sheffield.

(*c*) *Maternity Hospitals.*

There are no Maternity Hospitals situated in the Urban District. Where Institutional Confinement is required or desired, the following hospitals or maternity homes are available :—

Montagu Hospital, Mexborough—Maternity Ward.
Hallamshire Maternity Hospital—Chapeltown.
Listerdale Maternity Home, Rotherham R.D.
Moorgate General Hospital, Rotherham—Obstetric Unit.

The services of Jessop Hospital, Sheffield, are also available for abnormal obstetric cases.

2.—Tuberculosis Scheme.

The Regional Hospital Board is now responsible for the clinical control of the Tuberculosis Dispensaries. The Consultant Tuberculosis Officers have a dual appointment with the Regional Hospital Board and the Local Health Authority ; thus a close liaison is kept between Tuberculosis Officers and the Medical Officer of Health. Working in conjunction with the Tuberculosis Officers are special nurses known as Tuberculosis Health Visitors,and these nurses are attached to the staff of the Divisional Medical Officer. In this way, your Medical Officer is kept fully conversant with the activities of the Tuberculosis Clinic

and is able to work in harmony with the Tuberculosis Officer in dealing with the environmental factors involved in each particular case.

A Register of all notified cases of Tuberculosis both Respiratory and Non-respiratory, is kept by the Medical Officer of Health in his Department.

The following are the names of the Tuberculosis Officers and the times of the Clinics held :

Dr. E. Ratner, Exchange Buildings, Market Street, Mexborough.
Monday 10.30 a.m. ; Wednesday 10.30 a.m.

Dr. H. A. Crowther, Carnson House, Moorgate, Rotherham.
Friday, 10 a.m.—2 p.m.

3.—Venereal Diseases.

Treatment of Venereal Disease is also the concern of the Regional Hospital Board. There is no such Clinic in Wath-on-Dearne. Treatment and Diagnostic Clinics are held in the County Boroughs of Rotherham and Barnsley, and cases from Wath Urban District are normally referred to these centres. Treatment is confidential, but a Social Worker is employed by the West Riding County Council to work in liaison with the Venereal Diseases Officer and the Medical Officer of Health.

Treatment Centre : Queens Road, Barnsley.

Times of attendance :	*Men.*	*Women and Children*
Monday ..	10.30 a.m. to 12.30 p.m.	5.30 p.m. to 7.30 p.m.
Thursday ..	6 to 8 p.m.	Tues., Thurs., Friday, 2.30 to 4.30 p.m.

Treatment Centre : 12 Frederick Street, Rotherham.

Times of Attendance :	*Men.*	*Women and Children.*
Wednesday ..	9.30 a.m.—12.30 p.m. and 5.30—8.0 p.m.	—
Thursday ..	Nil	2—4.30 p.m.
Friday		5.30—7.30 p.m.
Saturday		9.30—12 noon.

4.—Ambulance Service.

The West Riding County Council are responsible for the provision of an Ambulance Service for the area. There is an Ambulance Depot at Dunford House, Wath. This depot provides a service for an extensive area, and has a sub-depot at Kiveton Park and Maltby. Formerly the Ambulance Service for the area was provided by ambulances attached to the Wath Wood and Rosehill Infectious Diseases Hospitals and the General Ambulance Service was operated from the Montagu Hospital, Mexborough.

5.—Laboratory Services.

These are now provided by the Sheffield Regional Hospital Board and the Public Health Laboratory at Wakefield.

PUBLIC AMENITIES PROVIDED BY THE DISTRICT COUNCIL

Open Air Parks.

There are two parks and a children's recreation ground in the district. One park is the Town Hall Grounds, which lie at the back of

the Council buildings. The entrances to the park are in West Street and Church Street. This park is open to all members of the public.

The grounds surrounding Dunford House are laid out as a flower garden and are open to adults as a Garden of Rest.

The need for outdoor recreation grounds for children is catered for at the Recreation Ground on Station Road.

Pensioners' Retreat.

Male Pensioners are catered for in that the Council have provided a Pensioners' Retreat at Dunford House. This was originally a warden's post, but was adapted during the year 1945 to the purpose for which it is now used. It is provided with tables, chairs, electric light and gas fire. There is a nucleus library. It was opened in July, 1945.

Montgomery House in High Street has also been opened as a Pensioners' Recreation Centre.

Swimming Baths.

The Council own a Public Swimming Bath. Bacteriological examinations of the water were carried out and the samples submitted were reported on favourably.

INFECTIOUS DISEASES.

Table A.

	Scarlet Fever	Pneumonia	Whoop. Cough	Measles	Food Poisoning	Erysipelas	Puerp. Pyrex.	Total.
Melton ..	5	—	7	21	—	—	—	33
Winterwell ..	6	—	14	45	—	1	—	66
East ..	2	3	1	64	—	—	—	70
Central ..	7	—	17	64	—	1	—	89
Wharncliffe ..	6	—	2	63	—	1	—	72
Total ..	26	3	41	257	—	3	—	330

Measles and Whooping Cough.

The year was characterised by the large number of children who were attacked by Measles (257) and to a lesser extent by Whooping Cough (41). Measles in particular is a difficult disease to control. Uncomplicated attacks are usually mild, but unfortunately there is always the danger of respiratory complications, such as Broncho-Pneumonia, or infections of the middle ear—leading to the familiar chronic otorrhoea—so often seen in the pre-school child. Urban communities are more vulnerable than those of the rural areas and measles thrives where overcrowding exists. There were only 5 months during the year in which no case of Measles was notified ; these were the months of July, August, September, October and December. The outbreak was a continuation of that of 1948, and there were 48 cases notified in January, 1949 ; 23 in February ; 96 in March. The incidence then declined sharply in April and May and no new cases were notified after the 11th June. The rest of the year was clear of measles with the exception of a small outbreak in mid November. An

attack of measles usually results in immunity, and second attacks are rare. Infants under 3 months seldom suffer from the disease as they are born more or less immune, provided that the mother has had measles. If the mother has not suffered from measles then of course her infant will not be immune.

The prevention and control of measles is difficult. Measles is accepted by the Public as a normal risk of childhood and its onset does not cause undue worry in the household. In the not very far past when one child in a family went down with measles the other children were deliberately exposed to infection so that they would get it and have done with it once and for all. Nowadays we believe that we should protect our children and that there is no reason why any child should necessarily become infected. Measles *per se* is a mild disease in a community long at risk, and probably where home conditions and medical attention are good no harm results—but unfortunately the heaviest incidence is often on those families who are ill-housed, and it is in those cases that complications are liable to occur. There may be some justification for Local Health Authorities to make available supplies of Gamma Globulin for issue to practitioners at the commencement of an epidemic and passive immunisation could then be given to children who are exposed to infection. By this means a local outbreak might be controlled. Naturally the Gamma Globulin would only be given to children who were known not to have previously had measles. *E.G.*—where an outbreak of Measles threatened a district all schools could be asked to categorise the pupils into :

(*a*) Those who had measles.

(*b*) Those who have not had measles.

Group (*b*) could be given passive immunity. A close watch could be then kept on this group to see the effect of the immunisation.

Similarly the pre-school child exposed to infection could receive passive immunity—especially those living in adverse conditions. By such means some measure of control might be feasible.

Education would also need to feature prominently in the prevention and control of this disease. Parents should realise that in bringing their children to the infected homes of their friends they are needlessly exposing them to infection.

41 cases of Whooping Cough were notified during the year. The outbreak commenced on the 1st October and ended on 31st December. One death due to Broncho-Pneumonia occurred. Our only weapon against this disease seems to be active immunisation. Much research has been done in trying to find a suitable Antigen for use as a prophylactic,but so far on the whole, results have been disappointing. Local Health Authorities are, as yet, chary of introducing combined immunisation against Diphtheria and Whooping Cough. We can with almost certainty immunise successfully against Diphtheria, but there is no such guarantee with Whooping Cough. Until the Medical Research Council can say with confidence that a sure antigen has been evolved most Local Health Authorities will not introduce schemes for inoculation against this distressing and crippling disease.

The significance of Measles and Whooping Cough as regards Public Health lies not only in the early deaths involved but to a greater extent in the morbidity which results from attack. Numerous children suffering from Bronchiectasis and chronic otorrhoea date the origin of their disability to an attack of either of these diseases. Broncho-pneumonia in itself may pave the way for Tuberculous infection. It is important to realise that very little is being done or can be done for the rehabilitation of toddlers and infants who are recovering from Whooping Cough. Yet it is of prime importance to ensure that the lungs which may have been extensively damaged by the paroxysms of coughing are returned to their normal state. This can only be done by arranging for those children who have had severe attacks to undergo rehabilitation by physiotherapeutic methods in suitable convalescent homes in the country. Such facilities can be said to be non-existent at present. True whooping cough takes a great deal out of a child and many children remain debilitated for many months after the attack; failure to gain weight coupled with loss of appetite are common sequelae, and as mentioned above, the disease like measles, predisposes to Tuberculous infection.

Scarlet Fever.

There were only 26 cases notified during the year. The cases were mild and no deaths were recorded.

Diphtheria.

Once more it is gratifying to be able to state that no case of Diphtheria occurred in the district during the year under review. One case was notified as suffering from queried Diphtheria but was not confirmed on clinical or bacteriological grounds. During the year 245 children received primary inoculation against the disease and 68 children received reinforcing doses. The aim is to immunise all children in their 1st year of life and to ensure that immunity is kept at a high level by giving them booster doses at age 5 (when they normally enter school) and again at 10 years. 53.3% of the child population of Wath-upon-Dearne have been immunised against the disease. Further comment on Diphtheria Immunisation is given in the Divisional report appended.

Procedure Adopted when a Notifiable Disease Occurs.

The General Practitioner notifies the Medical Officer of Health on a statutory form. The Medical Officer of Health informs the Sanitary Inspector, who visits the house and fills in a detailed report under various headings. School children (contacts) are instructed to remain off school for the incubation period of the disease, members of the household who are employed in food handling, etc., are kept off work until shown to be free from infection. Milk supplies are checked and the housing conditions noted. In the case of adverse housing the Medical Officer requires the case to be admitted to Hospital or also where a case occurs in a shop premises. In the case of young children the Health Visitor is informed of all details and instructed to keep in touch with the case until recovered. This is to ensure that skilled advice and help is given to the parents to safeguard the health of the child. Terminal disinfection is sometimes carried out, but facilities for the fumigation of bedding, etc., are not very

satisfactory. The Isolation Hospitals have agreed to disinfect bedding, clothing, etc., but charge a fee for this. Before the National Health Service Act the Local Authority had this done in their own right. The Local Authority is responsible for the transport of disinfected bedding, etc., back to the home. It is suggested that such bedding, etc., should be transported to and from the infected home by the ambulance service. Most Local Sanitary Authorities are too small to make separate transport arrangements for such work, and doubtless agreement would be possible between the Local Health Authority and the Local Sanitary Authority to cover this work.

Admissions to Hospital.

Cases of infectious diseases occurring in Wath-upon-Dearne are normally admitted to the Wath Wood Isolation Hospital, but cases are also admitted to the Kendray Isolation Hospital, Barnsley, and Badsley Moor, Rotherham. Listed below are details of the numbers of cases admitted to Infectious Diseases Hospitals during 1949 :

Wath Wood.

	Cases
Scarlet Fever	23
*Diphtheria	1
Measles	1
Pneumonia	1
Erysipelas	2
Chicken Pox	1
†Gastro-Enteritis	5
Total	34

*Queried case—proved negative.
†Not notifiable but admitted by arrangement.

TUBERCULOSIS.

At the end of 1949 there were 39 cases of Respiratory and 12 cases of Non-Respiratory Tuberculosis on the active register. Of the Respiratory cases 15 were known to be excreting Tubercle bacilli in their sputums. The names of one male and one female were removed from the register as having transferred to another area.

Three female names were removed from the register as having died of Respiratory Tuberculosis. The Tuberculosis death rate was 0.25 as compared with the rate for England and Wales which was 0.45.

Tuberculosis Deaths.

Respiratory.

Wath.	M.	F.
15—25	—	1
55—65	—	2

Seven (7) new cases of Respiratory Tuberculosis—two (2) males and five (5) females, and four (4) new cases of non-respiratory, four (4) females,

were notified during the year, making a total of 11 new cases for addition to the Register.

New Cases.

Wath.	Respiratory.		Non-Respiratory.	
	M.	F.	M.	F.
1—5	—	—	—	1
5—15.. ..	—	—	—	1
15—25.. ..	—	3	—	1
25—35.. ..	1	1	—	1
55—65.. ..	1	1	—	—

During the year five (5) cases from the district were admitted to Sanatoria for treatment and two (2) cases discharged. One case refused to avail of Sanatorium treatment.

There were at the end of the year the names of twelve (12) female and twenty-seven (27) male patients on the Register as suffering from Pulmonary Tuberculosis and there were three (3) males and nine (9) females suffering from Non-pulmonary Tuberculosis.

The problem of dealing with Tuberculosis is complex. From the Public Health aspect the objective is to discover, isolate and treat the new case as early as possible. Discovery, isolation and treatment of the new case is, however, merely the beginning.

It can be truthfully said of Tuberculosis that "case begets case" and where a new case is discovered our aim should be to find the original case from which it arose. The reservoir of Tuberculosis infection is in the old chronic cases and these are the very cases which are ignored by all. They are mostly living under adverse conditions, ill-housed and ill-cared for and yet these must of necessity be responsible for a great deal of our new cases. They are not eligible for admission to Sanatoria nor are they suitable for active treatment in the way of Artificial-Pneumothorax or Sanatoria care. They are in fact almost the rejects of society periodically visited by the Tuberculosis Health Visitor and the Medical Officer of Health—completely dependent for their income on the Tuberculosis Allowances granted under the National Assistance Act. These in effect constitute the reservoir from which the majority of new cases receive their infection. Since the Tuberculosis Officers were taken over by the Regional Hospital Board the Medical Officer of Health has practically nothing to do with the clinical aspect of the disease, nor has he any say in arranging for the Hospitalisation or removal to Sanatoria of any case occurring in his area. The clinical tuberculosis officer is now more and more concerned with the curative aspect of the disease and he, on his part, has lost the direct contact he heretofore held, with the local Medical Officer of Health. Slender life lines still exist. The Tuberculosis Health Visitor who attends the Tuberculosis Clinic is as yet still on the Staff of the Divisional Medical Officer and there still remains the line of personal contact between the officers concerned. It is nevertheless apparent that the Medical Officer of Health will have to formulate some scheme to deal with the chronic tuberculous person—the reject of the curative service—with a view to protecting Public Health from the risk to which these persons, unintentionally and unavoidably, at present expose it.

At the time of writing this report a survey is being carried out on every case of Tuberculosis occurring in the area. It is hoped during the coming year to give the result of this survey and I am confident that it will tend to focus attention on the inadequacies of our present schemes for dealing with the disease.

As a Local Sanitary Authority there is but little we can do but that little is of primary importance. Where Tuberculosis exists we should satisfy ourselves that the Housing conditions of the patient, and the family or other occupants at risk, are satisfactory. It is of great importance to ensure that the patient has a room to him/herself and that the sleeping accommodation is such that there is no overcrowding. It is often argued that the rents of council houses may be so high as to deter the patient from either applying for one or accepting one if offered ; this is understandable and while nowadays such patients are eligible for the Tuberculosis Allowance under the National Assistance Act, nevertheless, these allowances are minimal and do not compare in reality with the earning power of a fully employed man. I suggest that to further help the Tuberculous person, Rents should be subsidised by either the rates or the Ministry of Health or by National Assistance. Under the Tuberculosis Allowances a married man is allowed up to 14/- per week for rent and it is discretionary whether or not this allowance is increased. There is no hard and fast rule but in the main it can be said that Housing Authorities need not fear arrears of rent occurring in those cases of tenants who are in receipt of the Tuberculosis Allowances.

The Medical Officer of Health has the power to order the removal to an Isolation Hospital of any patient suffering from a notifiable infectious disease, if, in his opinion, the patient is liable to constitute a source of infection to others. If the Medical Officer of Health is satisfied that the home is unsuitable for the domiciliary care of such a patient, or if the case occurs in a shop premises or other place freely accessible to the Public, he can order the removal of the patient to Hospital. Similarly it is an offence for such a person, or those in charge of him, to permit him to travel in a public conveyance (buses, taxis, trams or trains). But in general, the Medical Officer of Health has no such powers in dealing with an infectious case of Tuberculosis ; and yet Tuberculosis is a greater menace to Public Health than most of the infectious diseases.

In outlining any scheme for the Prevention of Tuberculosis the following factors are in my opinion important :

1. When a new case is discovered prompt treatment should be instituted and the patient isolated. This is a matter for the Regional Hospital Boards to arrange. It is possible that empty wards in Isolation Hospitals could be staffed and adapted for the reception of early cases who are awaiting admission to proper Chest Hospitals or Sanatoria.

These patients would be under the clinical care of the area Tuberculosis Officer.

2. Provision should be made for the removal for a period, of child contacts in an infected household to a suitable Residential Open Air School—with facilities for X-Ray and clinical observation by a

Tuberculosis Officer, and immunisation with B.C.G. if Mantoux negative.

or

Where a case of Chronic Tuberculosis exists in a household that case should be admitted to a Sanatorium and all Mantoux Negative contacts should be immunised with B.C.G.

3. Where housing conditions are found to be adverse the Housing Authority should in general be prepared to rehouse the family at risk if necessary. In this they would have to abide by the opinion of the Medical Officer of Health and the Tuberculosis Officer.

4. *B.C.G.* Vaccination should be introduced as soon as possible and should become a regular feature of our Preventive Medical Services. It should be freely available at Dispensaries and Local Authority Clinics. I make no apology for giving below a short outline of B.C.G. Vaccine and its relationship to the Prevention of the Disease. B.C.G. stands for Bacille-Calmette-Gucrin, a strain of cattle Tubercle bacilli which have been grown under laboratory conditions and which are so attenuated that they are of a somewhat harmless type, and whilst incapable of causing active disease are yet sufficiently stimulating to the body tissues as to produce a reaction against tuberculosis. The body tissues then produce immunising bodies against the Tubercle bacilli. The vaccine has been used for many years in Scandinavian Countries. In 1947 the question of introducing vaccination against Tuberculosis in this country was raised and discussed at the International Conference on Tuberculosis in London.

Tuberculosis infection usually first occurs in early child life and as a rule is unaccompanied by symptoms. It does, however, sensitise the individual to the Tubercle bacillus and the infected person will then give a + reaction to the Mantoux test. (This test is carried out by introducing diluted Tuberculin into the skin). A Mantoux + reactor has some resistance to Tuberculosis. Such persons owe their resistance to previous infection with virulent Tuberculosis. So long as the general health of the body is good no active tuberculosis develops. If, however, the bodily resistances weaken (e.g., malnutrition, illness, poor housing and ventilation, etc.) the infected or original focus of disease may break down and active tuberculosis occur. It is interesting to remember that adult activation is usually a manifestation of the primary infection of childhood. Young persons who break down with Tuberculosis when exposed to infection are usually those who have not been protected by primary minimal infection in childhood. These young persons, had they been Mantoux tested prior to the onset of disease, would have been Mantoux negative. In other words they would not have responded to the provocation of Tuberculin. The point must now be clear that minimal infection with Tuberculosis in childhood can cause the body to develop a "resistance" against subsequent attacks, and so in general can be said to be advantageous. Unfortunately, we cannot control the risks attached to haphazard primary infection—and so we look for some substitute which can be given in controlled amounts and which, while harmless in itself, can yet produce in the body a resistance to infection akin to that produced by the

living bacillus. BCG is held to be a suitable substitute. Before undergoing BCG vaccination individuals must be Mantoux tested. If the person tested is Mantoux + we know that they are already infected or "Tuberculinised." If on the other hand the person is found to be Mantoux Negative we know that no infection occurred. All new born infants are Mantoux negative. At 21 years of age most persons in urban communities are Mantoux +. BCG is offered only to those who are Mantoux negative. Certain precautions are necessary but in general vaccination is offered to :

(a) Children who are Mantoux negative and are in contact with the disease or who live in households in which there is a case of Tuberculosis.

(b) Others who desire it and are suitable for vaccination.

(c) Mantoux negative nurses, etc., who may be exposed to infection. Before undergoing vaccination it is necessary to isolate the individual for 6 weeks to ensure that they are really Mantoux negative and that primary infection has not occurred since the last skin test. Two skin tests are done to ensure that the person is negative and then the vaccine (BCG) is given into the skin by hypodermic. The dosage is small 1/10 millilitre. It is essential (according to some authorities) to take precautions during the 3 weeks following inoculation to ensure that the individual is not exposed to natural infection. As soon as "conversion" has occurred the individual gives a + reaction to the Mantoux test, and resistance to further infection has been established. It is usual to vaccinate babies on the thigh and adults on the arm. A local reaction ensues and usually develops within 3 weeks. It takes the form of a papule or pustule and scabs over, somewhat like vaccination against Smallpox.

It can be seen then that BCG vaccination is more than a possibility. The Health Department in collaboration with the clinical tuberculosis officers of the Regional Hospital Board have now a weapon, which if intelligently used, can prove of great value in protecting infants and others from the ravages of Tuberculosis.

ANALYSIS OF THE CAUSES OF DEATH.

There was a total of 159 deaths assigned to the district during the year under review. 84 were in respect of females and 75 males.

1. Infant Deaths.

Fifteen (15) infants under one year of age died in the district during 1949. The deaths were in respect of 6 male and 9 female infants. Further comments on Infant Mortality are included in the Divisional Report contained at the end of the Annual Report. The Infant Mortality rate for Wath-upon-Dearne for the year was 60.48. The neo-natal death rate was 24.15—neo-natal deaths are deaths of infants within the 1st month of life. Six (6) infants died in this period during 1949.

2. Heart Diseases.

There were 60 deaths (23 males and 37 females) listed as being due to diseases of the heart, and these accounted for about 37% of the total deaths. Since last year the County Medical Officer's Department has started an investigation into certain heart diseases—especially those which affect the coronary arteries. In common with other Divisional Medical

Officers of Health, I am participating in this investigation and each Quarter make an analysis of the deaths due to coronary disease. It is certain that many cardiac deaths occur prematurely, and that many of these deaths are to a certain measure preventable. The conditioning of a disabled cardiac patient to a suitable occupation must in the future come to be part of our Industrial Health Scheme.

3. **Intra-cranial Vascular lesions.**

Deaths under this heading number 20, viz., 8 males and 12 females, and they account for approximately 12.6% of the total deaths. Such deaths are often due to high blood pressure leading to haemorrhages into the brain.

4. **Bronchitis.**

Bronchitis was given as the cause of 8 male and 3 female deaths and accounted for about 7% of the total deaths. At the time of writing this report an investigation is being instituted in the Southern parts of the West Riding into the genesis or evolution of such chest diseases as Bronchitis or Emphysema. The investigation is being conducted by the co-operative efforts of the Staff of a Sheffield Teaching Hospital, the County Medical Officer and the Divisional Medical Officers concerned.

5. **Infectious Diseases including Pneumonia, Influenza and Tuberculosis.**

Under these headings there was a total of 17 deaths ; 3 being due to Respiratory Tuberculosis ; 10 to Pneumonia and 2 to Influenza. Complicated Measles and Whopping Cough were responsible for the remaining two.

The Zymotic Death Rate for the year was 0.36.

6. **Cancer.**

7 males and 10 females died as a result of Cancer and these deaths accounted for 10.7% of all deaths. The only hope in combating this disease seems to lie in earlier diagnosis leading to early radial treatment. In my last year's report I suggested that diagnostic cancer clinics should be made available and suspected patients should not have to travel long distances to Cancer Institutes or clinics to avail of expert diagnostic opinion.

7. **Congenital Malformations and birth injuries.**

3 male and 2 female deaths were registered as being due to the above causes. Little can be done about the congenital malformations—which include meningocele, hydrocephalus and spina-bifida. We do not know, as yet, enough about the pre-natal life of the infant to be able to take any steps to prevent these errors of development. Birth injuries are, however, in a different category and many deaths from these causes could be said to be preventable. Birth injuries may be due to many factors :

(a) Premature birth leading to precipitate labour.
(b) Obstructed labour due to—
    (i) maternal causes such as contracted pelvis, placenta praevia, etc.
    (ii) Foetal causes, e.g., malpresentations, multiple pregnancy, disproportion
(c) Instrumental delivery.

It is within the power of obstetrical science to foresee many of these difficulties and take steps to avoid maternal and infantile mortality or morbidity. Ante-Natal care can forewarn us and skilled intra-natal care should ensure that the infant suffers minimal trauma in delivery. Instrumental delivery *per se* should never be lightly undertaken and the only real indications for this mode of delivery are maternal or foetal distress.

8.—There were no maternal deaths during 1949.

DEATHS FROM ALL CAUSES DURING 1949.

Cause of Death.	Males	Females
Typhoid and Paratyphoid Fevers	—	—
Cerebro-Spinal Fever	—	—
Scarlet Fever	—	—
Whooping Cough	—	1
Diphtheria	—	—
Tuberculosis of Respiratory System	—	3
Other forms of Tuberculosis	—	—
Syphilitic Diseases	2	—
Influenza	2	—
Measles	1	—
Acute Poliomyelitis and Polioencephalitis	—	—
Acute infective encephalitis	—	—
Cancer of buccal cavity and oesophagus (m) and uterus (f)	—	—
Cancer of stomach and duodenum	2	1
Cancer of breast	—	2
Cancer of all other sites	5	7
Diabetes	—	—
Intra-cranial vascular lesions	8	12
Heart diseases	23	37
Other diseases of circulatory system	1	2
Bronchitis	8	3
Pneumonia	2	8
Other respiratory diseases	4	1
Ulcer of stomach or duodenum	—	—
Diarrhoea (under 2 years)	2	1
Appendicitis	—	—
Other digestive diseases	3	1
Nephritis	1	—
Puerperal and post-abortive sepsis	—	—
Other maternal causes	—	—
Premature birth	—	—
Congenital malformations, birth injuries, etc.	3	2
Suicide	—	—
Road traffic accidents	1	1
Other violent causes	3	1
All other causes	4	1
Total from all causes	75	84

Section 47 of the National Assistance Act, 1948.

Section 47 deaths with the removal to suitable premises of persons in need of care and attention.

No action was taken during the year by this Authority.

SANITARY CIRCUMSTANCES OF THE DISTRICT.

Water Supply.

Bacteriological examinations were made regularly of the raw water and of the treated water after passing through the supply mains. Twelve examinations of treated water and twelve examinations of untreated water were made and all of them showed the highest standard of bacterial purity.

No exception can be taken to the water supply on the score of purity or palatability but some reference must be made to its undesirable hardness. The total non-volatile solids in treated Wath water is 1280 and the total hardness is 620. Of the total hardness 480 represents the permanent and 140 the temporary hardness. This is excessive. A full report on the water supply was given in the 1947 Annual Report. Hard water results in heavy additional costs to the budget of the average family. It causes rapid "furring up" of boilers in hot water systems leading to wastage of fuel and inefficient heating. Due to furring of kettles, pans, etc., it takes more gas or electricity to boil water. It is definitely wasteful of soap—as any housewife can confirm. To overcome the disadvantages of hard water the residents of the urban district must either instal at their own expense, a water softener or fall back on the use of detergents. Both involve an expensive outlay of money. Water softeners are in themselves expensive and furthermore they require more or less continual expenditure to maintain them in a reasonable condition of efficiency. The greater their capacity and efficiency the greater their cost. Water softeners suitable for fixation between the service water pipe and the house are beyond the reach of most members of the community, or involve a heavy burden on the householder in providing one. The proprietary brands of detergents sold in this area cost 1s. 6d. and 1s. 9d. for a 20 fluid ounce bottle. A bottle roughly contains enough detergent to treat about 50—60 gallons of water. An average family can use 3 bottles per week—adding 4s. 6d. to 5s. 3d. to the weekly budget. Detergents merely act by keeping the solids in the water in suspension and prevent their deposition as scum on the sides of basins, etc. They cannot be added to water used for cooking and are only applicable for making hard water usable for washing.

Untreated hard water forms scum on baths and wash basins and causes deposits to form in kettles, etc. It doubles at least the energy required to complete the weekly wash and rewards the housewife with poor results for her extra efforts. In addition to its effects on household work it adds highly to the overhead costs of Industrial concerns. Industries depending on steam raising plants need to provide expensive water softening plants and the maintenance costs of their boilers, etc., are considerably raised.

In general, the disadvantages of a hard water supply outweigh the advantages. The disadvantages are not always apparent to those residents who have long resided in the area but are more noticeable to persons coming to the district from soft water areas. A person used to soft water will find a great difference in using even a moderately hard water. It is well to realise that in many matters taken for granted by the residents of the area, the opinion of the outside observer or non-resident may be of more value insofar as it is unbiased by native pride or customary usage. Wath water must rank as one of the hardest in England.

SEWERAGE.

The only extensions to sewers have been in respect of the Newhill Housing Scheme and there have been no important additions to the Sewage Disposal Works. Certain items of plant have, however, been renewed.

HOUSING.

The Registrar-General's estimate of the population of the Urban District for 1949 was 13,780.

The number of dwelling houses in the Urban area at the end of 1949 totalled 4092—and of these 14 were of the back to back type.

If the population was evenly distributed into the number of dwelling houses available, the average number of occupants per house would be 3.4 and in theory no rehousing problem would then exist. At the time of writing this report there are 715 housing applications lodged with the Housing Manager. Shewn below is a tabulated statement in an analysis of the total applications plus the addition of 56 tenants who desire "exchanges" :—

Ward	From Tenants	From Lodgers	Bungalows	Total
Central	64	92	18	174
East	82	67	15	164
Melton	54	67	8	129
Wharncliffe.. ..	17	78	18	113
Winterwell	67	51	13	131
Non-Residents ..	.. —	—	4	4
	284	355	76	715
Exchanges				56

Applicants can be broadly classified into one or the other of the following categories :—

1. Lodgers, especially married couples with children living under overcrowded conditions and young married couples living with their in-laws.

2. Tenants of the Sub-standard houses who desire better housing conditions.

3. Aged persons desiring the tenancy of a bungalow.

4. Persons who require rehousing for reasons of health, e.g., the Tuberculous of whom there are 12 on the current application list.

5. Parents who have large families, with sons and daughters over the age of 10 years.

6. Persons living in condemned houses, e.g., back-to-back. (In this case where the Council are granted a demolition order by the Courts, the Council has the onus of rehousing the tenants.)

7. Officials, including Policemen, Teachers, Local Government Officers, etc.

Each and every applicant in these categories has a case for rehousing. It is difficult for the Council to formulate any rigid scheme for the allocation of houses as they become available. It is the statutory duty of the Council to abate overcrowding. On medical grounds it is imperative to rehouse, where necessary, the Tuberculous. The importance of this is twofold, viz., to ensure that the patient has the ideal environment for recovery and to ensure that he can be isolated from other members of the household to prevent infection. During the year, 50 houses were known to be overcrowded and those were occupied by 69 families comprising a total number of 417 persons. 10 families were relieved of overcrowding during the year involving a total of 84 persons.

Two families were rehoused on the grounds of Tuberculosis during the year.

It can be said in general that apart from primary applications for houses from young married couples, the bulk of other requests are from those families who (1) share a house, (2) who live in overcrowded conditions or (3) live in sub-standard homes.

Housing Progress during 1949.

No. new houses (Permanent) erected by the Council	72
No. new houses erected by private enterprise	5
Total	77

It is interesting to note that the last census taken in 1931 showed the population of Wath-upon-Dearne to be 13,655 (125 less than the Registrar-General's estimate for mid 1949) and that there were then 3,375 inhabited houses. It can be seen that 717 houses have become available since 1931 and yet the population has increased by only 125.

WATH-UPON-DEARNE URBAN DISTRICT COUNCIL

Annual Report of the Sanitary Inspector for the year 1949.

To the Chairman and Members of the
Wath-upon-Dearne Urban District Council.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to submit my report for the year ending 31st December, 1949.

Sanitary Inspection of the District.

During the year the following inspections were made :—

Nature of Inspection.	Number of Inspections made.
Houses, *re* Housing Structural Defects	503
Houses, *re* Overcrowding	39
Houses, *re* Vermin	167
Premises, *re* Nuisances	1256
Smoke Observations	1
Refuse Collection	19
Refuse Disposal	51
Shops (under Shops Act)	1
Cowsheds	35
Dairies	16
Ice Cream Premises	17
Preserved Food Premises	1
Food Shops, Vans and Stalls	32
Restaurants and Canteens	19
Factories	28
Bakehouses	3
Caravans	4
Common Lodging Houses	7
Rats and Mice Infestation	144
Miscellaneous Inspections	111
Total	2454

Complaints Received.

251 Complaints were received at the office during the year and are classified as follows :—

Nature of Complaint.	Number of Complaints Received.
Choked or leaking drains	71
Defective waterclosets	35
Defective sinks	11
Defective eaves gutters	4
Defective yard paving	4
General housing defects	71
Dirty premises	4
Overcrowding	12
Defective dustbins	3
Accumulations	7
Vermin and other insect pests	11
Keeping of animal nuisances	5
Smoke nuisances	2
Complaints *re* refuse collection	1
Miscellaneous	10
	251

Particulars of Notices served under Public Health Acts.

Number of written informal notices served requiring nuisances and defects to be remedied	236
Number complied with	212
Number of verbal intimations given	113
Number complied with	91
Number of statutory notices served	34
Number of statutory notices complied with by owner or occupier	*42
Number of notices where work executed in default	*13

* Including notices complied with during 1949 which were served in 1948.

Nature of Defects remedied under Public Health Acts.

Choked drains, gullies, etc., cleansed	87
Drains re-constructed	8
Watercloset fittings repaired or renewed	73
Additional waterclosets provided	3
Watercloset structures repaired	38
Dirty waterclosets cleansed	3
Sinks renewed	18
Sink waste pipes renewed or repaired	20
Dustbins renewed	28
Accumulations removed	10
Keeping of animal nuisances abated	17
Dirty and/or verminous premises cleansed	15
Yards paved	7
Coal store structures repaired	11
Roofs repaired	27
Chimneys repaired	10
Eaves gutters and fall pipes cleansed, renewed, or repaired	15
External walls repaired	12
Boundary walls repaired	1
Wall and ceiling plaster repaired	87
Windows repaired	27
Fireplaces and cooking ranges repaired or renewed	24
Stairs repaired	1
Floors repaired	5
Washing coppers repaired	5
Doors repaired	3
Dampness remedied	2
Dangerous structures demolished	2
Miscellaneous defects remedied	3

HOUSING.

Housing repair work proceeded only slowly during the year. Building firms appeared to be fully engaged on work other than the repair of dwelling houses, and it was usually impossible to secure repairs without considerable delay. Much damage arising from subsidence of the ground due to coal mining operations was met with. Some houses seriously damaged in 1946 by subsidence are still awaiting repairs ; in other instances where repairs were executed further damage occurred. Subsidence damage results in a serious lowering of the standard of housing accommodation because of the tendency to accept as a normal thing the fractured walls and ceilings, dis-repair, and poor state of internal decoration of the house.

1. *Inspection of Dwelling Houses during the year* :—

(1)	(a)	Total number of dwelling-houses inspected for housing defects (under Public Health or Housing Acts)	163
	(b)	Number of inspections made for the purpose ..	503
(2)	(a)	Number of dwelling-houses (included under sub-head (1) above), which were inspected and recorded under the Housing Consolidated Regulations	11
	(b)	Number of inspections made for the purpose ..	71
(3)		Number of dwelling-houses needing further action :—	
	(a)	Number considered to be in a state so dangerous or injurious to health as to be unfit for human habitation	Nil
	(b)	Number (excluding those in sub-head (3) (a) above) found not to be in all respects reasonably fit for human habitation	163

2. *Remedy of Defects during the year without service of formal Notices* :—

Number of defective dwelling-houses rendered fit in consequence of informal action by the Local Authority or their Officers	83

3. *Action under Statutory Powers during the year* :

A.		Proceedings under Sections 9, 10 and 16 Housing Act, 1936 :—	
	(1)	Number of dwelling-houses in respect of which notices were served requiring repairs	6
	(2)	Number of dwelling-houses which were rendered fit after service of formal notices :—	
		(a) By owners	6
		(b) By Local Authority	4
B.		Proceedings under Public Health Acts :—	
	(1)	Number of dwelling-houses in respect of which notices were served requiring defects to be remedied	8
	(2)	Number of dwelling-houses in which defects were remedied after service of formal notices :—	
		(a) By owners	6
		(b) By Local Authority in default of owners	Nil
C.		Proceedings under Sections 11 and 13 of the Housing Act, 1936 :—	
	(1)	Number of representations, etc., made in respect of dwelling-houses unfit for habitation	Nil
	(2)	Number of dwelling-houses in respect of which Demolition Orders were made	Nil
	(3)	Number of houses demolished in pursuance of Demolition Orders	31

D. Proceedings under Section 12 of the Housing Act, 1936 :—

(1) Number of separate tenements or underground rooms in respect of which Closing Orders were made .. .. Nil

(2) Number of separate tenements or underground rooms, the Closing Orders in respect of which were determined, the tenements or rooms having been rendered unfit .. .. Nil

4. *Housing Act*, 1936—*Part IV—Overcrowding.*

(a) (1) Number of dwellings overcrowded at the end of the year 50
(2) Number of families dwelling therein 69
(3) Number of persons dwelling therein 417

(b) (1) Number of new cases of overcrowding reported during the year 6

(c) (1) Number of cases of overcrowding relieved during the year 10
(2) Number of persons concerned in such cases .. 84

5. *New Houses.*

By the Local Authority : Permanent type 72
Temporary type .. .. Nil
By Private Enterprise 5

6. *Housing Conditions.*

(a) Total number of houses in the district 4092
(b) Number of working class houses included in above .. 3928
(c) Number of back-to-back houses 14

Sanitary Accommodation.

The following table shows the number of dwelling-houses and other buildings in the District and the sanitary accommodation provided thereat :—

Ward.	Dwelling-houses.	Dwelling-houses with Shops included in Column 1.	Shops and Factories.	Miscellaneous Buildings.	Privies.	Water-closets.	Fixed Ashpits. Wet.	Fixed Ashpits. Dry.	Dustbins.	Cesspools.	Slop-closets.
Central ..	1224	44	47	40	14	1659	6	11	1271	2	–
East	721	32	11	9	21	831	8	2	722	4	–
Wharncliffe	775	25	25	15	—	916	—	2	845	–	–
Winterwell	643	42	26	12	2	732	1	2	674	–	1
Melton ..	729	27	23	17	—	801	—	4	741	1	–
Totals ..	4092	170	132	93	37	4939	15	21	4253	7	1

Tents, Vans and Sheds.

Only one caravan used for human habitation is stationed in the District. Inspections were made when vans were brought into the District for short periods as it is usually found that nuisances arise through lack of proper drainage and means of refuse disposal. One such instance occurred when a van was stationed on a children's playing field for several weeks.

Cleansing of Verminous Premises.

Inspections were made where occupants of old and possibly infested houses were to be re-housed in Council houses. The furniture and effects belonging to seven families were fumigated with hydrogen cyanide in course of removal.

Liquid insecticides containing D.D.T. or Gammexane were applied in 9 houses for the destruction of bed-bugs, and in 10 houses for the destruction of cockroaches, this work being carried out by the Local Authority. In addition, 2 houses were sprayed for beetles, 2 for red mite and 1 for lice infestations.

The following houses were cleared of vermin by the occupiers: 8 houses of cockroaches, 1 of bed-bugs.

Rodent Destruction.

10% of the whole of the foul sewer manholes in the District were baited to test for the presence of rats early in May, and infested portions of the sewers were treated for destruction of rats in May and December.

The following table records the work carried out by the department in addition to the treatment of the sewers. Although very few dead rats are found after treatment, it must be remembered that baiting has mostly taken place in rat holes and the probability is that in most of these instances the rats would die in their burrows. In some instances, however, the bodies have been found weeks after the treatment when "cleaning up" operations have been carried out.

Type of Premises.	No. of Premises Treated.	Rats or Mice.	Type of Treatment.	Estd. Kill.	No. of Dead Bodies Found.
Sewage Works ..	2	Rats	Poisoning	90	2
Dyke Bank	1	Rats	Poisoning	20	Nil
Allotments	2	Rats	Poisoning	15	Nil
Dwelling-houses ..	10	Rats	Poisoning	67	Nil
Schools	1	Rats	Poisoning	8	Nil
Canteens	2	Mice	Trapping	—	38
Dwelling-houses ..	1	Mice	Trapping	—	4
Totals	19			200	44

Atmospheric Pollution.

Atmospheric pollution in the district arises mainly from 4,000 domestic chimneys, 2 or 3 industrial chimneys and 2 coke oven plants. On the domestic front smoke abatement advances slowly. Owners and

occupiers of dwelling-houses are gradually replacing the coal fired washing boiler with a gas boiler, and the old fashioned Yorkshire range with a modern range or other modern appliances. Steps should be taken to ensure that the improvements of this nature necessary to make a considerable reduction in atmospheric pollution are made at a much quicker rate. A great reduction in soot fall is possible and would bring about a much needed sanitary improvement in the District, particularly in the congested areas.

FACTORIES ACT, 1937 AND 1948.

Part 1 of the Act.

1. *Inspections for purposes of provisions as to health (including inspections made by Sanitary Inspector).*

Premises. (1)	M/c. Line No. (2)	Number on Register (3)	Number of			M/c. Line No. (7)
			Inspections. (4)	Written Notices. (5)	Occupiers Prosecuted. (6)	
(1) Factories in which Sections 1, 2, 3, 4, and 6 are to be enforced by Local Authorities ..	1	11	5	1	Nil	1
(2) Factories not included in (1) in which Section 7 is enforced by the Local Authority ..	2	35	18	8	Nil	2
(3) Other premises in which Section 7 is enforced by the Local Authority* (excluding out-workers' premises)..	3	5	5	—	Nil	3
Total ..		51	28	9	Nil	

2. *Cases in which Defects were found.* (If defects are discovered at the premises on two, three or more separate occasions they should be reckoned as two, three or more "cases").

* Electrical Stations Institutions and sites of Building Operations and Works of Engineering Construction.

Particulars.	M/c. Line No.	Found.	Remedied.	Referred		Number of Cases in which Prosecutions were Instituted.
				To H.M. Inspector.	By H.M. Inspector.	
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Want of Cleanliness (S.1)	4	1	1	—	—	—
Overcrowding (S.2) ..	5	—	—	—	—	—
Unreasonable temperature (S.3)	6	—	—	—	—	—
Inadequate Ventilation (S.4)	7	—	—	—	—	—
Ineffective drainage of floors (S.6) ..	8	—	—	—	—	—
Sanitary Conveniences (S.7) :—						
(a) Insufficient ..	9	10	—	—	8	—
(b) Unsuitable or defective ..	10	2	—	—	—	—
(c) Not separate for sexes ..	11	—	—	—	—	—
Other offences against Act (not including offences relating to outwork)	12	—	—	—	—	—
Total ..		13	1	Nil	8	Nil

Public Swimming Bath.

Purification of the swimming bath water is carried out by the continuous filtration and chlorination system (chloramine process). Four samples of water from the swimming bath were submitted to the Central Public Health Laboratory for examination, the results being as follows :—

Sample No.	Presumptive B.Coli in 100 ml. of Water.	p.H. Value.	Free Chlorine in 1,000,000 parts of Water.
1	None	7.1	0.5 parts
2	None	7.3	0.2 parts
3	None	7.3	1.0 parts
4	None	7.4	1.0 parts

INSPECTION AND SUPERVISION OF FOOD.

Milk Production.

The duty of inspection of cowsheds and dairies at dairy farms passed from local authorities to the Ministry of Agriculture on the 1st October, 1949, and the report therefore deals with this work up to that date.

13 farms were registered as dairy farms on the 30th September, 1949. Milk production had been discontinued at one farm during the year. 27 cowsheds were in use housing approximately 160 milk cows. Inspection of all cowsheds in use was made during the year and the standard of cleanliness in milk production found to be fairly satisfactory. "Accredited" milk was produced under licence at four farms.

12 samples of milk were obtained and submitted to the Central Public Health Laboratory for bacteriological examination, and all were reported satisfactory. Particulars of these samples are as follows :—

Ungraded Raw Milk.

Producers No.	Date Sample Taken.	Place Sample Taken.	Age of Milk when Sampled.	Result of Methylene Blue Test.
26	2/2/49	Farm	Nil	Satisfactory
26	16/3/49	Farm	Nil	Satisfactory
26	7/4/49	Farm	Nil	Satisfactory
6	2/2/49	Farm	Nil	Satisfactory
6	17/5/49	Farm	Nil	Satisfactory
7	2/2/49	Farm	Nil	Satisfactory
19	16/3/49	Farm	Nil	Satisfactory
4	7/4/49	Farm	Nil	Satisfactory
1	17/5/49	Farm	Nil	Satisfactory

Samples of "Accredited" Milk.

Producers No.	Date Sample Taken.	Place Sample Taken.	Age of Milk when Sampled.	Result of Methylene Blue Test.
24	2/2/49	Farm	Nil	Satisfactory
11	7/4/49	Farm	Nil	Satisfactory
8	7/4/49	Farm	Nil	Satisfactory

NOTE.—A sample is regarded as satisfactory which is not decolourised at the end of 4½ hours if it has been taken between the 1st of May and the 31st October, or at the end of 5½ hours if taken between the 1st November and the 30th April.

Biological Examination of Milk.

One sample of milk was submitted to the laboratory for biological test. The sample proved negative.

Distribution of Milk.

The administration of the Milk and Dairies Regulations, 1949, except in relation to dairy farms and the registration of dairy farmers, falls on local authorities. There is much room for improvement in the methods adopted in the conveyance and distribution of milk, and it is hoped that the application of the new regulations will help to bring this about.

Designated Milk.

Two supplementary licences, one to sell "pasteurised" and the other to sell "Tuberculin Tested" milk by retail, were granted. Two dealer's

licences to retail "Tuberculin Tested" milk, one dealer's licence to retail "pasteurised" milk, and one dealer's licence to retail "sterilised" milk were also granted.

The proportion of designated milk sold in the district has increased considerably.

Inspection of Meat and other Foods.

Under centralised slaughtering arrangements the meat supply for this district comes from Sheffield Abattoir. None of the six slaughter houses in the District was in use for slaughtering purposes during the year with the exception of three of the buildings which were used in connection with the slaughter of cottagers' pigs.

Inspection of Cottagers' Pigs.

Number of cottagers' pigs slaughtered	323
Number of cottagers' pigs inspected	323
Number of carcases in which some part was condemned for disease other than Tuberculosis	2
Number of carcases in which some part was condemned for Tuberculosis	14

The following foodstuffs were condemned at food shops :—

Article.	No. of Cans, Jars, or Packets.	Weight.
Canned Meat	2	6 lbs.
Canned Fish	2	1 lb.
Milk	22	30 lbs.
Preserves	26	28 lbs.
Vegetables	33	50 lbs.
Fruits	6	40½ lbs.
Sauce and Pickles	55	51 lbs.
Coffee Essence	4	1½ lbs.
Cereals	15	14 lbs.
Cake	—	37 lbs.
Tonic Wine	1	—
Cheese	—	5 lbs.
Sausage	—	1½ lbs.
Suet	—	½ lb.
Rabbits	432 No.	1290 lbs.
Hares	6 No.	45 lbs.
Fish	—	182 lbs.
Totals ..	604	1783 lbs.

In all cases the foods condemned were surrendered by the owner and collected and destroyed by the local authority.

Inspection of Premises used for the sale of Food.

An increased number of visits was made to canteens with a view to improving the standard of cleanliness in the handling and preparation

of food. Improvements in connection with the water supply, cooking and dishwashing equipment was found to be urgently necessary at one canteen.

With the coming into operation of the new bye-laws with respect to the handling and wrapping of food more time will have to be spent on the inspection of food shops and similar food premises.

Ice Cream Premises.

During the year six shops were registered for the sale of ice cream. In each case the registration was approved subject to the condition that only "pre-packed" ice cream should be sold from properly refrigerated storage accommodation in the shop. There are now 10 shops in the district registered for the sale of ice cream, and one building registered for the manufacture and sale of ice cream.

Three samples of ice cream were purchased and submitted to the Central Public Health Laboratory for bacteriological examination, the results being as follows :—

Sample No.	Shop or Vehicle.	Date Purchased.	Result of Methylene Blue Test.	Provisional Grade.	Remarks.
21	Shop	17/5/49	2 hours	3	Portion cut from block
22	Vehicle	17/5/49	2 hours	3	Loose
23	Shop	17/5/49	2 hours	3	Pre-packed

PUBLIC CLEANSING.

Refuse Collection.

A weekly collection of refuse from all premises at which dustbins are in use is the standard set by the Council, and this has been fairly well maintained for many years. This standard was maintained in 1949. Each dustbin was emptied on 51 occasions during the year, the loss of one week during the 52 weeks arising from the observance of public holidays.

2829 loads of refuse were collected during the year, the estimated total weight being 3,800 tons.

Refuse Disposal.

All refuse other than salvage was tipped at the Wet Moor Lane refuse tip. Controlled tipping methods are practised and no complaint of nuisance from the tip was received during the year. The quantity of waste materials sold as salvage shows a further increase, due largely to increased collections of waste paper from shop premises, and the salvage of tins at the tip.

The following statements show in tabulated form the work done and the materials salvaged during the year ended 31st March, 1950.

Refuse Collected.

Receptacles Emptied.	Number.	Number of Loads of Refuse.
Dustbins	208,586	2,684
Dry Ashpits	215	39
Privies	53	11
Shop Refuse	728	95
Total number of Loads ..		2,829

Disposal.

Shop refuse delivered to Salvage Depot	95	loads
House and trade refuse delivered at tip by freighters ..	2734	„
Refuse tipped by private owners' lorries	76	„
Refuse tipped by other Council Departments	909	„
Total number of loads disposed of	3814	„

Sale of Salvage.

The weights of the various types of material sold and despatched during the year were as follows :—

Materials.	Weight.			
	Tons.	Cwts.	Qrs.	Lbs.
Waste Paper	101	4	3	13
Rags	6	11	0	0
Bones	1	1	0	16
Bottles and Jars	4	15	2	20
Non-ferrous Metals	—	7	1	24
Scrap Iron and Steel ..	11	8	0	0
Scrap Tins	37	1	3	0
	162	9	3	17

I thank the Chairman and Members of the Council for the support and encouragement they have given to me during the year, and the Officers of the Council for their assistance and co-operation.

I am, Ladies and Gentlemen,

Your obedient Servant,

W. W. WILKINSON,

Sanitary Inspector.

COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

Divisional Scheme of Preventive Medical Services

Division No. 26

Comprising the Urban Districts of

Wath-upon-Dearne, Swinton and Rawmarsh

Divisional Health Staff

Divisional Medical Officer and Divisional School Medical Officer :

Dr. ANTHONY EUSTACE, M.B., Ch.B., B.A.O., L.M., B.Sc., D.P.H.

Assistant County Medical Officer :

Dr. M. R. MENZIES, M.B., Ch.B., D.C.H.

Part Time Medical Officers :

Dr. D. PINDAR, M.B., Ch.B.
Dr. D. CHAPMAN, M.B., Ch.B.
Dr. H. A. ADAM, M.B., B.Ch.
Dr. I. CAMPBELL, M.D.
Dr. G. J. O'KEEFFE, M.B., Ch.B., B.A.O.
Dr. L. H. COPPING, M.B., Ch.B.

Specialists :

W. L. ROWE, Esq., M.B., Ch.B., F.R.C.S. (Ear, Nose and Throat).
E. G. HERTZOG, Esq., M.B., B.S. (Orthopaedics).
Dr. C. C. HARVEY, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P. (Paediatrics).

Health Visitors :

Wath-upon-Dearne . .	Miss C. Lascelles Miss E. McBride	Mrs. R. Robinson
Swinton	Miss B. E. Smith	Mrs. D. L. Adsetts
Rawmarsh	Mrs. C. M. Sheldon Mrs. M. Jenkinson	Miss E. E. Smith

Home Nurses :

Wath-upon-Dearne ..	Miss C. W. Winch	Miss H. Coxon
Swinton	Miss M. Linegar	Mrs. E. Firth
Rawmarsh	Miss M. Welton Miss M. Hirst	Miss N. A. Rodgers Mrs. A. E. Moore

Midwives :

Wath-upon-Dearne ..	Mrs. A. Hessam Mrs. V. Beaumont	Miss M. Barber Miss A. Vernon
Swinton	Mrs. F. Launders Mrs. M. Woodhouse Mrs. V. Tunney (Relief)	Miss M. Linegar Mrs. N. Parker
Rawmarsh	Miss M. Welton Miss N. Plant	Miss L. Bamford Mrs. J. Savage

Clerical Staff :

Mr. James Chambers (Chief Clerk).

Other Clerical Staff :

Mr. J. P. Hyland	Mr. G. Cree	Miss A. Watson
Mrs. E. Owen	Mrs. P. Copeland	Miss D. Caldwell

PUBLIC HEALTH SERVICES UNDER PART III OF THE NATIONAL HEALTH SERVICE ACT, 1946.

Summary of Vital Statistics, 1949.

Area of Division	7,990 acres
Estimated Population	44,240
Birth rate (per 1,000 estimated population)	18.37
Death rates (per 1,000 estimated population) :	
All causes	10.48
Cancer	1.36
Heart and Circulatory	3.41
Diarrhoea under 2, per 1,000 live births	6.15
Zymotic	0.16
Respiratory diseases	1.47
Respiratory Tuberculosis	0.20
Other Tuberculosis	Nil
Total Tuberculosis	0.20
Maternal Mortality	Nil
Infant Mortality (Rate per 1,000 live births) ..	36.90

STATISTICS FOR URBAN AND RURAL DISTRICTS IN THE WEST RIDING AND ENGLAND AND WALES FOR 1949.

Annual Rates per 1,000 of the Estimated Population.

	Live Birth Rate.	Death Rate.	Zymotic Death Rate.	Respiratory Diseases Death Rate.	Heart and Circulatory Diseases.	Cancer.	Tuberculosis Death Rate.	Infant Mortality Rate.	Diarrhoea Deaths under 2 per 1,000 Live Births.	Maternal Mortality.
Division 26 ..	18.37	10.48	0.16	1.47	3.41	1.36	0.20	36.90	6.15	Nil
U.D.'s in West Riding	16.8	12.5	0.08	1.48	4.36	1.88	0.37	37	3.01	0.75
R.D.'s in West Riding	18.4	10.8	0.09	1.31	3.70	1.61	0.37	42	3.95	1.03
Administrative County	17.2	12.1	0.08	1.44	4.19	1.81	0.37	38	3.27	0.83
England and Wales ..	16.7	11.7	*	*	*	*	0.45	32	3.0	—

* Figures not yet available.

1. Organisation and General Administration.

The year 1949 saw a gradual but obvious increase in the amount of clerical work which engaged the attention of the Divisional Staff, and as all the services became more developed, fresh fields were covered and additional duties were imposed. The Establishment for the clerical staff of the Divisional Office has remained the same since August, 1948. The County Council as Local Health Authority became responsible for the services under Part III of the Act from 5th July, 1948. During 1949 there were many changes in the Divisional (medical, nursing and clerical) Staff.

The School Medical Service was completely overhauled and the clerical work entailed and the organisation and arrangements for School Clinics were taken from the Assistant County Medical Officer and was undertaken by the Divisional Clerical Staff. This greatly relieved Dr. Menzies of much of her clerical work and made for a better and more efficient School Medical Service. Extra clerical staff is urgently required to cope with the increased work in connection with the School Medical Services, Home Help Services and the Local Sanitary Services.

One of the many ways in which Divisional organisation helped the Nursing staff, was in relieving the Health Visitor of the sales and clerical work entailed in Dried Milk Foods. I arranged during the latter part of 1948 for all the Clinics to be covered by a clerk from the Divisional Office thus allowing the Health Visitor to devote her time to the proper sphere of Health Education. The pressure of work, however, in the Divisional Office has necessitated the withdrawal of all clerical assistance from the Clinics during 1949.

During the year the need became apparent in the Parkgate district for an Infant Welfare Clinic and the West Riding Health Committee agreed to proposals to open an Infant Welfare Centre at the Methodist Church, Parkgate. This Clinic was opened on 23rd February, 1949. The Clinic has proved a great success and fully justifies its inception. The need for a School Clinic in Parkgate was also realised and this was opened in July, 1949. The Clinic is attended by Dr. M. R. Menzies, Assistant County Medical Officer.

I am also contemplating the provision of an Infant Welfare Clinic in the Kilnhurst area of the Swinton Urban District and negotiations are well on the way for such a Clinic to be opened during the coming year.

2. **Care of Mothers and Young Children.**

(*a*) *Infant Health and Mortality.*

Estimated Population	44,240
Number of Live Births	813
Number of Premature Births (domiciliary and institutional)	45
Number of Stillbirths	30
Number of Infant Deaths	30
Birth Rate (per 1,000 estimated population) ..	18.37
Stillbirth Rate (per 1,000 live and still births) ..	35.58
Infant Mortality Rate (per 1,000 live births) ..	36.90
Estimated Child Population (0–4 years)	4,122
Estimated Child Population (5–14 years)	7,483

The Infant Mortality rate for the Division for 1949 was 36.90 as compared with 58.5 in 1948. This rate can be considered satisfactory for such an industrialised area. In all 30 infants died in their 1st year of life—15 in their own homes and the remaining 15 in hospitals. Of the total deaths 16 occurred in the neo-natal period giving a neo-natal death rate of 19.6. Of the 16 neo-natal deaths 11 occurred in hospitals and 5 in their own homes. 6 of the infants died within the first 24 hours of life and 7 within the first 3 days of life. During the year there were also 30 stillbirths—giving a still birth rate of 35.58 per 1,000 live and still births.

The Infant Mortality rates for the Urban Districts were Rawmarsh 26.94, Swinton 25.97 and Wath-upon-Dearne 60.48.

Wath-upon-Dearne figure gives much cause for concern, especially when reviewing the Domiciliary Infant Deaths. Out of 15 Infant deaths in that part of the Division, 11 occurred at home. High in the list of causes of death was Broncho-Pneumonia (6). There were also 2 deaths from Gastro-Enteritis. I regard at least 50% of Broncho-Pneumonia deaths as preventable if skilled attention is given *early on*. The onus is essentially on the parents to seek early medical aid for ailing infants. I have instructed all Health Visitors in the Division to impress upon mothers that if "baby becomes ill" to let the Family Doctor and Health Visitor know at once. The Health Visitor keeps in contact with the case, visiting *daily*, and I have told them to see the General Practitioner

as often as possible. The Health Visitor keeps me informed of progress. On the other hand I have informed all General Practitioners in the area that every assistance possible in the treatment of sick infants will be given —including the issue of the Sorrento Cot, Oxygen, Home Nurses and assistance in obtaining beds for Pneumonic and Gastro-Enteritic babies. I have appealed to all concerned in the prevention of infant mortality to take personal pride in trying to produce low rates. Much work has to be done by the Divisional Medical Officer in the Health Education of the Division. There is limited scope for this and it is hoped that more opportunity may come to develop this side of our programme during the coming year. It is difficult to get publicity regarding infant health but the work goes on slowly mainly through the efforts of our Health Visitors and through the part-time Clinic Medical Officers. Health Education is a speciality in itself and needs special training methods—such training is given to all D.P.H. candidates or full time Assistant County Medical Officers. A practitioner is mainly concerned with curative medicine but I would like to see the General Practitioner encouraged to take active interest in the Preventive Medical Services. Preventive medicine is a specialism and we should, therefore, use only specialist officers to conduct its services.

Brief comment is given in an appendix on the Infant Deaths which occurred in this Division in 1948 and 1949. Our aim is to focus attention on the factors which influence infant deaths. The following list shows what in my opinion are important points in minimising the infant mortality rate :—

1. To ensure complete adequate ante-natal care whether at Clinic or Surgery.
2. To improve Domiciliary Hygiene—with special effort to advise expectant mothers to make the best of present conditions.
3. To provide full cover for mother and child during the pre-, intra and post-natal periods.
4. To make the best use possible of the Health Visitor and Home Nurse—especially during infant illness.
5. To stress the important role of the General Practitioner, the Paediatrician and the Hospital Service in preventing infant death.
6. To stress the value of the early use of the Antibiotic and Sulpha group of drugs.

Special problems arise in connection with :—

1. The premature baby—whether born at home or in hospital. The special facilities available for Domiciliary Prematures have been brought more than once to the notice of the General Practitioners, Midwives, etc.
2. The Erythroblastic infant.
3. The Gastro-Enteritic infant.
4. The Pneumonic infant.

Each of these has been briefly referred to in the appendix on Infant Mortality.

One disturbing feature of Preventive Medicine is the lack of a common meeting ground for the General Practitioners, the Medical Officer of Health and the Nursing Personnel. It is impossible to arrange for a good "get together"—where free discussion could be held. Yet it is apparent that all these people are vitally concerned in the lowering of the Infant Death rate and are equally responsible for the maintenance of Child and Community Health.

The Medical Officer of Health is responsible to see that every effort is directed towards reducing the number of deaths amongst infants, and has to prepare an annual report and make comment on the factors involved

2(*b*) **Child Welfare Centres.**

There are 5 centres for infant welfare in the Division. It was felt that a clinic was needed at Parkgate (a highly populated area of the Division with poor housing standards) and authority was given to inaugurate a clinic at the Methodist Church, Parkgate. This was opened on 23rd February, 1949. Clinics are held as shown in the tabulated statement below :—

Address of Centre.	Day and Times of Sessions.	No. who attended for 1st time during year.	Attendence of Children up to 5 years.
West Melton : Methodist Church, Princess Street.	Tuesday, 2—4 p.m.	132	1,808
Wath-on-Dearne : Dunford House, Doncaster Road.	Monday, 2—4 p.m.	164	2,255
Swinton : Rock House.	Monday, 2—4 p.m. Wednesday, 2—4 p.m.	583	6,016
Rawmarsh : Barber's Avenue.	Tuesday, 2—4 p.m.	277	4,551
Parkgate : Methodist Church.	Thursday, 2—4 p.m.	153	895

Attendances at the Clinics during the year totalled 15,525 in respect of 1,309 pre-school children. These can be considered as satisfactory returns. It is apparent that it is the better type of mother who attends the Infant Welfare Clinics and as Medical Officer of Health I am quite happy about these infants. I instruct the Health Visitors to pay minimal home visits to these infants—i.e., to only visit if they miss them at the Clinic. The concentration of Home Visiting is on sick babies and babies who are not brought to the clinics. The Clinics are staffed—with one exception—by part time Medical Officers.

2(*c*) **Ante and Post Natal Clinic Services.**

Ante-Natal Clinics are held at the following places and times :—

Address of Centre.	Day and Times of Sessions.	Total No. of Attendances.	
		Ante-Natal	Post-Natal
Wath-on-Dearne : Dunford House.	1st and 3rd Fridays 10 a.m. to 3 p.m.	433	56
West Melton : Princess Street.	2nd and 4th Wednesdays, 1.30–3.30 p.m.	133	5
Swinton : Rock House.	Thursday, 10 a.m. to 4 p.m.	990	20
Rawmarsh : Barber's Avenue.	Thursday, 9.30 a.m. to 1.30 p.m.	388	50

It was found necessary to make arrangements to close the Princess Street Ante-Natal Clinic, West Melton, during the year—its actual date of closure being 9th November, 1949. The few numbers attending did not warrant the continuation of the clinic and cases are now referred from West Melton to Dunford House.

The Clinic at Rock House is well attended ; 167 women attended the Clinic during 1949 and paid 990 visits. In addition 18 women underwent post-natal examination.

I am concerned about the Ante-Natal Clinic at Rawmarsh. This Clinic is not very well attended. It is in a modern building with every comfort and facility. There was a total of 388 visits paid by women attending the Clinic during the year—a very low total when compared

with Swinton or Wath, especially having regard to the fact that the Clinic serves the most populous area of the Division. 36 mothers attended for Post-Natal examination.

The Clinic at Dunford House was attended by 99 expectant mothers, who paid 433 visits. In addition 52 women attended for Post-Natal examinations.

30 women attended at the Princess Street Clinic giving a total number of visits of 133. In addition, 5 mothers attended for post-natal examination.

No special provision is made for the examination of post-natal cases and these are normally referred to and seen at the ordinary ante-natal sessions. A routine invitation is sent from the Divisional Office to all mothers who attended the Clinics for ante-natal care, to re-attend 6 weeks after confinement for a Post-natal examination.

It will be noted that only 111 women returned to the clinic for a post-natal examination. This represents only 22% approximately of Domiciliary Confinements. There is little necessity to stress the importance of post-natal examination but it is difficult to persuade mothers to attend for this purpose. "They feel all right" and that suffices. Educational methods are the only way to overcome this reluctance and though slow, will probably in time produce good results.

Brighouse Ante- and Post-Natal Hostel.

During the year one case was referred to this Hostel and received rest treatment. Difficulties are experienced in persuading eligible patients to avail themselves of the facilities as most women are reluctant to leave their children and husbands. Facilities for young children should be made available. Home Helps do not seem to be the answer.

2(*d*) **The Care of the Premature Baby.**

There was a total of 45 Premature Babies born in the Division in 1949. 25 of these were born at home and the remaining 20 in Hospitals.

During the year the County scheme for the succour of premature babies was introduced into the Division. All Midwives, General Practitioners, Health Visitors, and Home Nurses were circulated with details of the Scheme. A suggestion was made—unfortunately without result—to the nearby maternity units that a breast milk bank be formed. I have since been in touch with Rotherham General Hospital and have interested the Medical Superintendent in the idea, and hope that sometime in 1950 breast milk will be available for Prematures born on the district. Further reference to the prevention of prematurity is made in the appendix to the report which deals with Infant Mortality.

In addition to the 25 domiciliary live born prematures there were also 5 still born.

The weights of the 25 domiciliary live born premature babies are given in the tabulated statement below :—

Weight in lbs. ..	$3\frac{1}{2}$	4	$4\frac{1}{2}$	$5–5\frac{1}{2}$	
Number of Prematures	2	3	7	13	Total 25.

Of these babies 24 had survived at the end of 28 days. One (1) baby died within 1 day of birth ; this baby weighed between 5–5½ lbs.

2(*e*) Flying Squad Arrangements.

There is a Flying Squad for obstetric emergencies on the District based at the Moorgate General Hospital, Rotherham. All practitioners and midwives have been circularised about this facility. So far as ascertainable the flying squad was called to the Divisional area on 3 occasions during 1949.

2(*f*) Infectious Diseases—Pemphigus Neonatorum.

There were 5 cases of Pemphigus Neonatorum notified as occurring in the domiciliary practice of County Midwives during the year. Each case was visited by the Medical Officer of Health. Bacteriological examinations were carried out and the organisms isolated were phage typed. In no case was the midwife found to be responsible. None of the cases were severe and all affected infants recovered rapidly with no after effects.

Puerperal Pyrexia.

Two cases were notified during the year ; neither was of serious import. One case was removed to an Isolation Hospital but recovery was uneventful.

2(*g*) Maternal Deaths.

There were no maternal deaths during the year.

2(*h*) Dental Treatment for Expectant and Nursing Mothers.

Dental treatment is offered to all mothers attending the Ante-natal Clinics. They are informed that they have the choice of availing of the services of the Local Health Authority Dental Surgeon, or a Private Dental Practitioner. At Dunford House the expectant mother is referred to the Dental Officer on the same day as she first attends. Our aim is to include routine Dental examination on the first visit of all expectant mothers. Unfortunately many mothers are frightened of dental treatment—and unless they have toothache they are reluctant to undergo preventive treatment. This leads to many broken appointments—a wastage of time and effort really for all concerned. Private practitioners also operate a priority scheme for expectant and nursing mothers.

2(*i*) Birth Control Clinic.

A Birth Control Clinic is held at Rock House, Swinton. There are three sessions per month, viz. : a morning and afternoon session on the 2nd Friday of each month and an afternoon session on the fourth (4th) Friday. The Clinic is conducted by Dr. M. M. Owen with the assistance of Miss B. E. Smith (Health Visitor). The Clinic caters for Divisions Nos. 22, 24, 25, 26, 30 and 31. The Clinic is administered by this Division. The procedure for making appointments is as follows. Practitioners and Clinic Medical Officers refer their cases to the appropriate Divisional Medical Officer who in turn makes an appointment for the patient through this office. The Divisional Medical Officer of the Division referring the case is then

informed of the date and time of the appointment and he passes the information on to the patient. There has been much misunderstanding regarding the functions of a Local Health Authority Birth Control Clinic; many practitioners and clinic medical officers were evidently under the impression that this clinic could be used as a family planning unit. It has been necessary during the year to circularise all medicos in the area and the Divisional Medical Officers of the feeder Divisions to the effect that the Clinic caters only for women referred on specific medical grounds and that these grounds must be such that any future pregnancies would be detrimental to the health of the mother. So far as I am aware the circular issued by the Minister of Health on the subject of Local Authority Birth Control Clinics dated March 1931 (Memorandum 53/MCW) did *not* authorise Local Authorities to establish separate Birth Control Clinics but only gave limited permission to give birth control advice to women for specific medical reasons. Two amending circulars have been issued by the Ministry in July 1931 and May 1934, but both insisted that the only purpose of the Local Authority Clinic (included in the Ante-Natal Clinic) was to advise mothers whose health would be impaired by further pregnancy. I have advised the Medical Practitioners in the area that they should refer cases who desire birth control advice merely for economic or other reasons to the Family Planning Association Clinic at Attercliffe, Sheffield, and have emphasised that only cases referred on medical grounds will be seen at Rock House.

It is suggested and hoped that the Regional Hospital Boards will assume responsibility, through their Gynaecological Departments for women referred on medical grounds and that the Family Planning Associations will continue to give advice to non-medical cases.

The following are the statistics for the Birth Control Clinic, Rock House, for 1949 :—

No. sessions.	No. attended 1st time.	Total attendances.
35	129	778

3. **Health Visiting.**

The establishment of Health Visitors for this Division totals 9 and at the end of 1949 only 5 qualified Health Visitors were available on the Divisional Staff together with 2 Assistant Health Visitors. In a compact industrialised area like Division 26, it is considered that a fully qualified Health Visiting Staff is essential to carry out the multifarious duties which are now required to be discharged by the Health Visitor. An attempt has been made during the year to encourage the qualified Health Visitor to devote more of her time to the home visiting of sick babies, cases of infectious diseases, additional school medical work and to leave the running of School Clinics and Specialist Clinics to the Assistant Health Visitors as a matter of routine.

During the year the staffing of the Ante-Natal Clinics was reviewed and the domiciliary midwives were given the greater share in the running of the Ante-Natal Clinics with the idea of each midwife attending the Clinic and being present with the Clinic Doctor at the examination of her own booked patients. This relieved the Health Visitor of a great

deal of work and allowed her to devote more time to talks to the expectant mothers on various health matters ; but the actual supervision of the Clinic, maintaining of records are still in the hands of the qualified Health Visitor. This revised method of staffing the Ante-Natal Clinics has worked very successfully during the year under review.

It would be remiss of me not to mention the retirement during the year of two long-service Health Visitors, i.e., Miss E. McBride in West Melton and Miss M. Newbould in Swinton. Both these Health Visitors have a fine record and their places have been very difficult to fill.

4. **Midwifery—Institutional and Domiciliary.**

There are no hospitals with Maternity Units or Maternity Homes located in this Division. We are served as regards Institutional Midwifery by Mexborough Montagu Hospital, Rotherham Moorgate General Hospital and the Hallamshire and Listerdale Maternity Homes. Abnormal cases can also be referred to the Jessop Hospital for Women, Sheffield. The number of Institutional Confinements notified during the year totalled 332 and by far the greater majority of these (167 births) were confinements of mothers normally resident in the Rawmarsh Urban District. I have commented on the Ante-Natal Clinic facilities in the Rawmarsh District in my report under the Ante-Natal Clinics for the Division. Cases of early discharge from hospitals are notified to the Divisional Office by telephone and the domiciliary midwife is then informed to take over the case. This aspect of Institutional Confinements has worked satisfactorily.

With regard to domiciliary midwifery, there are 11 midwives in the Division and two district nurse-midwives and the total number of domiciliary confinements notified during 1949 was 508 (496 live births and 12 still births). All the midwives possess the Gas and Air Certificate and a Minnett's Gas and Air Analgesia Machine. This service has expanded considerably during 1949. There were 131 cases where Gas and Air Analgesia was administered during the year and this figure is considered to be very satisfactory. A system exists in the Division whereby a short memorandum prepared by me is now issued at the Ante-Natal Clinics to all expectant mothers giving them full information regarding the facilities available and the method of use of the Gas and Air Machine. This has proved of great propaganda value and will be continued in the future. It is also proposed for the coming year, to arrange for all mothers attending the Ante-Natal Clinics to be examined at the 8th month of pregnancy as to their fitness to undertake Gas and Air Analgesia irrespective of whether they have indicated their willingness at that time to avail themselves of the service. The idea envisaged is that should a mother change her mind during labour the necessary certificate will then have been completed for the midwife concerned.

During the year the Sorrento Cots were issued 12 times for Premature babies and in no case was there a death of a premature baby who was nursed in the cot. All midwives are aware that the Sorrento Cots, of which there are 3, are available at any time of the day or night

for issue by the Ambulance Depot at Dunford House. Two of the midwives have undergone special residential training at the Sorrento Hospital, Birmingham, on the care of the premature infant, and their services are availed of as required.

During 1949 the new scheme of the Ministry of Health to allow priority in the purchase of private motor cars by domiciliary midwives resulted in 7 midwives obtaining new cars during the year. The possession of a private motor car by a domiciliary midwife is now appreciated to be essential especially when it is borne in mind that it would be impracticable to carry a Gas and Air Machine on the district by any other means.

279 Medical Aid Notices were issued by the Midwives in this Division during the year and a tabulated statement is given below. As might be expected, by far the greatest number of Medical Aid Notices were issued in respect of difficulties experienced during "Labour."

Medical Aid Notices.

Type of Case	No. Issued because of complications arising in/during			
	Pregnancy.	Labour.	Lying-in.	The Child.
(i) Where the Medical Practitioner had arranged to provide the patient with maternity medical services under the National Health Service Act	11	50	18	21
(ii) Others	33	91	22	33
Total	44	141	40	54

5. Home Nursing.

The Home Nursing Services which were taken over by the County Council as Local Health Authority, have developed considerably and closer liaison with the General Practitioner in the Division has been constantly emphasised and fostered. The number of cases which have been visited by the 7 Home Nurses in the Division helped by the part time Relief Home Nurses, totalled 19,608 during the year which gives a good idea of the increasing range of the Home Nursing Service.

The General Practitioners in the Division have been apprised of the Home Nursing facilities available. They are utilising the services provided to a greater degree than was formerly the case. During the year applications were received from various re-habilitation authorities for the supply of Dunlopillo Mattresses to paraplegic cases and these have been supplied by the County Council.

There were three Nurses' Homes at the beginning of the year, but owing to the non-occupancy of the Home at West Melton and its unsuitability for conversion to other requirements and needs, it was decided to relinquish these premises. The Nurses' Home at Parkgate is fully residential and has domestic staff employed, whilst the Nurses' Home at Swinton provides furnished accommodation for one Home Nurse and one Health Visitor. The checking of the Inventories at the Nurses' Homes has been completed but the administrative work entailed in maintaining these inventories up-to-date is proving rather heavy.

Only two Home Nurses in the Division possess a private motor car and it is considered that this is a serious hindrance to the development of the services as a car is essential for the carrying out of their duties. I feel that a greater degree of priority in the supply of new motor cars will be a great help for the Home Nurses and for the service generally.

The Local Hospital Management Committee, by their policy of allowing a County Council Health Visitor to act as Care and After-Care Liaison Officer at the Hospitals in this area, has proved of great value in providing up-to-date information on the discharge of patients who require Home Nursing care after hospital treatment. This system is working extremely well and the prompt furnishing of reports by this Officer for the information of the Home Nurses is appreciated. A further scheme which provides for the reporting on housing conditions in respect of patients admitted to hospital and also particulars of all discharges has now been inaugurated by the Rotherham and Mexborough Hospital Management Committee. A considerable number of these forms pass daily through the Divisional Office for completion. The extra amount of work involved in this scheme is considered to be outweighed by the natural advantages which are obtained and the closer liaison which has now been cemented. The old established role of district nurse in dealing with chronic illnesses, sick and infirm, needs to be revised. While these duties are essential we should not lose sight of the fact that by developing the Home Nursing Service to cover most of the acute illnesses in the home, under the guidance and supervision of the family physician, the natural result would be to minimise the need for hospital beds for certain medical cases.

6. **Home Helps.**

The demand for the provision of Home Helps during 1949 increased tremendously and this was due, no doubt, to the publicity which the service attracted.

During the year there was a total of 167 cases provided with Home Helps. The number of part-time Home Helps on the Register increased from 19 to 41 and there were periods during the year when more than 41 Home Helps were actually employed. It is considered that the employment of part-time Home Helps is the only possible method in this part of South Yorkshire as the majority of women will not accept

whole time employment on a salary basis but prefer to be employed part-time with breaks between the cases. Owing to the fact that there is very little work in this part of the Riding for female labour there is an almost unlimited source for the recruitment of Home Helps and it has, therefore, been possible to select the Home Helps on our current register with due care and discrimination.

The Nursing Staffs have been instructed to visit at least once per week but in a Division which has over 40 Home Helps on the Register it is considered that the supervision of the services from all aspects could better be fulfilled by a Supervisor appointed for that purpose.

In conclusion it is obvious that the domestic help service is becoming more popular and it is necessary for a very close and detailed check to be made into the circumstances of every applicant, before the services of a Home Help can be authorised. This check on the home circumstances of each applicant is carried out by a Health Visitor and a special Questionnaire compiled to suit all purposes has been devised. As stated in my Annual Report for 1948 it does seem that the former help which could be expected from neighbours and relatives is now a thing of the past.

7. **Diphtheria Immunisation and Vaccination.**

During the year steady progress was made with regard to Diphtheria Immunisation and I set out at the end of this section the statistics relating to diptheria immunisation for the year 1949. The high immunisation rate which has prevailed in Swinton is noteworthy. I am also happy to report that no case of Diphtheria has been confirmed since Divisional administration commenced.

Facilities are freely available for diptheria immunisations at the Infant Welfare and School Clinics and also through the General Practitioner service. A good deal of propaganda work has been done by the Health Visitors during their visits to infants and I consider that present satisfactory results will tend to continue. No special clinics for diphtheria immunisation are held in the Division but it was found a most satisfactory scheme to cover a school at a time and then conduct a few sessions to clear off the outstanding numbers. It is hoped during the coming year to introduce propaganda films on Immunisation as part of the general Health Education Service.

With regard to the combined prophylactic for Diphtheria and Pertussis, arrangements for this have not yet been brought into operation by the County Council but the combined prophylactic is being administered by many General Practitioners in the Division and Record Cards are being completed only in respect of Diphtheria Immunisation. No statistics are available as to the number immunised against Whooping Cough but the requests for such immunisation can be considered fairly widespread.

Statistics relating to the Diphtheria Immunisation for the Urban Districts of the Division for the Year 1949 :

Urban District.	No. of Children Immunised in 1949.			No. of Children given booster doses during 1949.	No. of Children Immunised at any time up to 31/12/49.			Estimated Mid-Year Child Population.			Immunisation Rate.
	Under 5-Yrs.	5—14 Yrs.	Total.		Under 5 Yrs.	5—14 Yrs.	Total.	Under 5 Yrs.	5—14 Yrs.	Total.	
Wath-upon-Dearne	221	63	284	68	644	1149	1793	1268	2019	3287	54.5%
Swinton	211	42	253	35	538	1721	2259	1084	1682	2766	81.6%
Rawmarsh	318	157	475	316	768	1595	2363	1770	2782	4552	51.9%

Vaccination against smallpox ceased to become compulsory from 5th July, 1948, and the results of this are reflected in the figures given below. The fall off in the numbers of vaccinations carried out reveals a shocking sense of apathy on the part of the parents and it is only when an outbreak of Smallpox takes place that a stimulus is given. The total number of persons vaccinated during 1949 for the whole Division was 13 and no other comment on this low figure is necessary. Valiant attempts have been made to disseminate propaganda on the value of vaccination through the Health Visiting Staff, but the deep rooted inertia which is so obvious will take much time to remove. In Swinton Urban District there were no infants under one year of age vaccinated at all and here again it is felt that the value of a suitable instructional film would do much to encourage vaccination in the Division.

Number of Persons Vaccinated (or Re-vaccinated) during Period

Age at 31/12/49 i.e., born in years.	Under 1 1949	1—4 1945/48	5—14 1935/44	15 or over before 1935	Total.
Number vaccinated :					
Wath	4	1	–	3	8
Swinton	–	–	1	2	3
Rawmarsh	2	–	–	–	2
Number re-vaccinated :					
Wath	–	–	1	1	2
Swinton	–	–	–	2	2
Rawmarsh	–	–	–	–	–

8. Ambulance Services.

The County Ambulance Service provided for this area has its Depot Headquarters at Dunford House and the service is now administered directly by the County Ambulance Officer as a separate department. Close liaison is maintained with this depot and it is extremely advantageous being located in the same building as the Divisional Office, and in addition an extension telephone line has recently been installed. An arrangement exists with the Ambulance Depot regarding the issue at any time of the day or night of the Premature Baby Unit.

9. Mental Health Service.

The visitation and general social care of Mentally Defective persons and certain aspects of some persons suffering from Mental Illness is carried out by Miss C. M. Ball, the Mental Health Social Worker, who also carries out these duties in Division 31.

The lack of Institutional accommodation and Occupation Centres for Mental Defectives is proving a great handicap in this work, but the visits paid by Miss Ball help to reassure the parents that these patients are not entirely forgotten in the new extended Health Services available for the general public.

Home circumstances reports are completed and general information ascertained in respect of patients in Mental Deficiency Institutions. History of Illness reports are supplied to the Medical Superintendent of Middlewood Mental Hospital on request in respect of patients admitted. Miss Ball is endeavouring to help patients who have had treatment in a Mental Hospital and returned home. Difficulties are often experienced by the relatives taking an antagonistic attitude towards the patient and this can often be altered by guidance towards a sympathetic and tolerant attitude. Assistance can also be given by the Social Worker making contacts with Ministry of Labour Officials and other people in respect of suitable employment which gives confidence to the patient.

The M.O.H. visited personally every case under statutory supervision during the year.

10. Food Hygiene.

All the Local Sanitary Authorities in the Division have adopted the Model Byelaws issued by the Ministry of Food, and it is hoped that these will come into operation in the near future.

31 cases of suspected Food Poisoning were reported during the year, and one of these cases was confirmed on investigation.

A separate report was submitted to the Wath-upon-Dearne Council at the end of November on a suspected outbreak of Food Poisoning which occurred at the Westville Club, West Melton. A special report was also submitted in respect of an outbreak of suspected Food Poisoning at Netherfield Lane Infants School, Rawmarsh, on 1st July, 1949.

11. Tuberculosis.

B.C.G. Vaccination.

A memorandum which I prepared and circulated to all medical and nursing personnel as well as the Urban District Councils in the Division is attached as an Appendix (b).

Tuberculosis Register.

I list below the number of cases of Respiratory and Non-Respiratory Tuberculosis in each Urban District of the Division, as at 31st December, 1949 :—

	Respiratory.		Non-Respiratory.	
	M.	F.	M.	F.
Rawmarsh	31	14	13	6
Swinton	25	22	11	12
Wath-upon-Dearne ..	26	11	3	11
Totals ..	82	47	27	29

Total number of notified cases in the Division = 185.

The service is now clinically controlled by Tuberculosis Officers of the Regional Hospital Board. It is regrettable that Medical Officers of Health have been divorced from this aspect of the disease—especially when many of them once held positions as Tuberculosis Officers. There

is no full-time Tuberculosis Health Visitor attached to this Division—but we have the part time services of Miss D. B. Dodds and Miss L. Robinson. Two Dispensaries serve the Division, viz.: Carnson House, Moorgate, Rotherham (Rawmarsh), and Mexborough for Wath and Swinton. We are now concerned mainly with the environmental aspect of this disease, and the social significance of this illness cannot be over-emphasised. Of latter months we have obtained some measure of priority in the matter of rehousing people who suffer from this grave condition. It is my ultimate aim to complete detailed investigation into every case of Tuberculosis on the active Register and to make recommendations to all concerned in the treatment, care and housing of these individuals. It is my opinion that the Tuberculosis Service is retrogressing as a result of its separation from the Local Health Authority.

Extra Nourishment.

The administration for the provision of extra nourishment to Tuberculous persons was undertaken by this Division in October, 1949. The total number of orders issued from the Division for the 3 months ended 31/12/49 was 30. The method of administration is cumbersome and could be modified to advantage.

Notification of New Cases, 1949.

	Respiratory.	Non-Respiratory.
Males ..	17	6
Females ..	16	8
Totals ..	33	14

Deaths.

Nine (9) deaths occurred during the year.

12. **Prevention of Illness—Care and After-Care.**

During the year a start was made on health education and propaganda through the medium of the Central Office of Information film shows. These instructional film shows were arranged to be shown to the mothers on various aspects of mothercraft and baby care. The first show was held in the Multiple Clinic, Rawmarsh, and was a tremendous success. Further shows were given in other parts of the Division and eventually it is hoped to arrange other instructional film shows on Ante-Natal care, Gas and Air Analgesia, etc., for the benefit of the expectant mothers. Leaflets and posters regarding various diseases, dental care, food handling, etc., have been circulated throughout the Division. I feel that these film shows are a source of tremendous propaganda value and I wish to record my indebtedness to Mr. Dixon of the Central Office of Information, Leeds, for his co-operation and help.

Issues of equipment under Section 28 of the Act were almost entirely confined to the supply of Dunlopillo mattresses for paraplegic cases and special beds for old cases of poliomyelitis. Stocks of heavy nursing equipment such as wheelchairs, crutches, bedpans, etc., are held at the Divisional Public Health Office and the Nurses' Homes at Swinton

and Parkgate, for issue on loan to patients, but additional equipment of all kinds is needed to satisfy the requirements of the expanding Home Nursing Service.

The Rotherham and Mexborough Hospital Management Committee have agreed to a scheme of liaison with the local health authorities for notifications of all admissions and discharges to be sent to divisions for completion regarding socio-medical conditions. These notifications are completed by the Health Visiting and Home Nursing Staffs and the scheme is proving highly successful and informative.

Convalescent Home treatment for patients recommended by their own doctor is provided by the County Council on a scale of charges similar to that applicable for domestic helps. Several cases were recommended for Convalescent Home treatment during 1949, and the facilities available are now being utilised to a greater extent by general practitioners in the Division.

13. **Atmospheric Pollution.**

Pollution of the atmosphere is a very real problem in this Division—especially in the Parkgate area of Rawmarsh. The Division occupies a highly industrialised compact space with Iron and Steel and Coal Mining as the main occupations. Bearing in mind that the area in acres of the Division is 7,990, the extent of the pollution can be visualised when attention is drawn to the number of inhabited houses and the number of heavy industrial plants it contains :—

No. of inhabitated houses (1949) = 12,667.

Heavy Industries :

(a) *Mines.*
- Manvers Main (Wath).
- Wath Main.
- Kilnhurst (Swinton).
- Stubbin (Rawmarsh).
- Aldwarke (Rawmarsh).

(b) *Forges, Foundries, etc.*
- Baker & Bessemers Steel Works, Kilnhurst.
- Dale, Brown—Glass container manufacturers, Swinton.
- Parkgate Iron & Steel Co., Rawmarsh.
- Waterstone Glass Works, Wath.
- Oxley's Steel Works, Parkgate.

(c) *Others.*
- Ward's Mineral Water Works, Swinton.
- Exley's Mineral Water Works, Rawmarsh.
- Rotherham Chemical Works.
- Yorkshire Tar Distillers (Kilnhurst).
- North Eastern Railway Loco Sheds.
- Midland Railway Loco Sheds, etc.

The concentration of heavy industries together with the network of Railways with their Loco sheds, and the subsidiary industries of the coal mines, e.g., Coke Ovens, etc., produce an atmospheric pollution which at times defies description.

During the year a member of the staff of the Industrial Fuel Research Station, Greenwich, visited the area and was much impressed by what he saw. Since then (through the West Riding County Council) we have installed a smoke filter, a deposit gauge, and lead peroxide apparatus at Rawmarsh. We hope at the end of 1950 to give some facts and figures as to the degree of pollution which exists.

The three Local Sanitary Authorities are members of the Sheffield Smoke Abatement Society. I cannot say that the membership has proved of any value. Nothing has been done to abate the existing conditions since the advent, at any rate, of Divisional Administration. I have tried to impress the Local Councils that they must give a lead by installing smokeless grates in their new Council houses and have put forward the germ of the idea of providing a communal hot water supply. The following factors have a real influence on atmospheric pollution in this Division :—

1. The area is a mining and steel making area and these industries constitute the bread and butter of the major part of our inhabitants.
2. Each Pit worker gets concessionary coal to the extent of 9–10 tons per annum. This is a normal perquisite of his employment.
3. The higher cost of gas and electricity would militate against persuading most people to accept smokeless heating and cooking arrangements.
4. Members of the Urban District Councils—many of whom are employed in mines and heavy industries—may individually feel disinclined to propose the installation of smokeless methods of heating. A collective policy would soften this.
5. Would a pit worker accept a bonus in lieu of free coal especially if this bonus was subject to Tax deduction ?

In tackling the problem my aims for 1950 are :—

1. To try to get the Housing authorities to adopt smokeless grates and heating methods for council houses.
2. To encourage consideration of a communal hot water system.
3. To foster the idea of supplying *coke* instead of coal to pit workers. Every effort should be made by the National Coal Board to reduce the cost of coke.
4. To propagate the idea that all railways in a coal belt area should be electrified or failing that Diesel locomotives should be used instead of coal burners.
5. To insist on skilled stoking methods of all boilers and to encourage courses for boilermen.
6. To encourage the National Coal Board to supply coal of correct calorific value to heavy industries.
7. To publicise the harm caused to health and property by atmospheric pollution.

14. SCHOOL HEALTH SERVICES.

The year was extremely busy and the total number of periodic and special inspections was 4,862. Dr. M. R. Menzies, the Assistant County Medical Officer, undertakes the bulk of the School Medical work and I attend the School Clinic at West Melton and carry out all examinations under the Mental Deficiency and Education Acts requiring completion of Forms 2 H.P. and M.D.1.

The programme of visits to schools, school clinics, special sessions are all organised by the Divisional Office and in addition the clerical work of issuing invitations to 15 school clinics per month is done by the clerical staff of the School Health Section. All defects found in school children requiring specialist treatment are referred in the normal manner to the Divisional Office for an appointment to be made to attend the appropriate Clinic, i.e Orthopaedic, Paediatric, Oculist or Ear, Nose and Throat.

Number of inspections carried out within Division No. 26 during 1949 :—

Entrants	698
Second Age Group—last year in Primary School ..	450
Third Age Group—last year of School Life	535
Total	1683

Other Inspections.

Number of Special Inspections	47
Number of Re-inspections	3132
Total	3179

Pupils Found to Require Treatment.

Entrants	50
Second Age Group	40
Third	44
Total	134

Classification of the General Condition of Pupils Inspected during the year 1949.

	A Good	B Fair	C Poor
Entrants	151	532	15
Second Age Group	96	348	6
Third Age Group	161	371	3
Total ..	408	1251	24

Ophthalmic Services.

The number of cases awaiting appointment for the Oculist Clinic during the year grew tremendously and concern was felt that the clinics which are held for one week out of five in the Division were not sufficient to keep abreast of the mounting number of cases. The Services of an additional School Oculist at the end of the year relieved the situation and the position is now satisfactory.

During the year we were much concerned by the time which had elapsed between the issue of a prescription to a school child and the date upon which the glasses were delivered. The delay was undoubtedly occasioned by the great demand made by adults under the National Health Service Scheme. A random survey was, therefore, undertaken and 32 parents were asked to notify me whether or not the spectacles prescribed at the November/December 1948 Oculist Clinics had yet been received. An analysis of this survey is given below which was reported to the Divisional Executive Education Committee for their information.

A further survey on the same lines is being conducted at present.

November–December, 1948 Clinics.

32 requests for information sent to parents on **13th June, 1949** ; 26 replies received.

Analysis.

Glasses not yet obtained	19		
„ received in February	1	(2/12	Waiting List)
„ „ „ March	1	(3/12	„)
„ „ „ April	2	(4/12	„)
„ „ „ May	3	(5/12	„)

Ear, Nose and Throat.

This specialist clinic session which is now held one Friday afternoon per month is not sufficient to meet the number of cases requiring treatment. A strict system of priority exists with regard to each case, but even so there are still 98 cases at the present moment awaiting appointment. Prior to his transfer to the Regional Hospital Board, Mr. W. L. Rowe held two E.N.T. sessions per month at Dunford House, but only one session is now authorised. Five cases a month are referred to this Divisional clinic by Division 25 at Wombwell.

Orthopaedic Clinic.

An orthopaedic clinic is held twice a month at Barbers Avenue, Rawmarsh, and these clinics cover cases from this Division and Division 31 at Rotherham. The service is extremely satisfactory, there is no waiting list, and the number of sessions is quite ample. In addition, the Orthopaedic Nurse conducts a special treatment session weekly.

Paediatric Clinics.

A Paediatric Clinic is held by Dr. C. C. Harvey once a month at Barbers Avenue, Rawmarsh, and this recently inaugurated specialist service has proved very welcome and instructive. A close liaison is

maintained with Dr. Harvey who attends the Divisional Office following each Paediatric Clinic to dictate letters to the family doctors in each case. Full particulars of this Clinic have been circulated to the General Practitioners in the Division who are now availing themselves of Dr. Harvey's services. 59 patients made a total of 84 attendances at the 14 Paediatric Clinic sessions held during the year.

Convalescent Home Treatment for School Children.

In addition to the normal course of recommending school children for convalescent home treatment after an examination and completion of Form 4 H.P., arrangements were made during the year for a number of vacancies to be allocated to this division at the Rotherham Home for Children at Filey. This home is a voluntary organisation which caters for children requiring a period of convalescence but who are not in the same need as those for whom a 4 H.P. is required. The vacancies allocated to this division were easily filled and the number of children who were sent to the Filey Home towards the close of the summer of 1949 was 13.

Speech Therapy.

No Speech Therapist is available in this part of the County for cases requiring treatment and this is a serious defect in the School Medical Service.

Ultra Violet Ray Clinics.

During the year a further Ultra-Violet Ray Clinic was established at Dunford House in addition to the clinic operating at Barbers Avenue, Rawmarsh. The facilities now available for Ultra-Violet Ray treatment are very satisfactory and the attendances at the two clinics during the year totalled Wath 168 ; Rawmarsh 2,828.

Sessions are held twice weekly at both clinics and advantage of these services is being taken to a greater extent by the General Practitioners in the Division.

Infestation with Vermin.

Difficulties with regard to non-co-operation by parents in the cleansing of verminous cases have been fairly apparent, and this was accentuated in no small measure by the lack of precise information on the powers and duties of School Nursing Staff under Section 54 of the Education Act. It therefore appeared advisable to set out in a simple fashion the salient points of this Section of the Act, and this has cleared up many difficulties. Headteachers in the Division have been asked to co-operate by not readmitting any school child who has been excluded by the School Nurse until passed as clean by the nurse concerned. The exclusion notices used are the forms printed in triplicate ; one copy for the parent, one copy for the headteacher and the third copy for retention in the book. It is appreciated that these forms were intended for use primarily for infectious conditions but it has been decided to extend their use to verminous conditions as this entails no separate forms and the type of form is particularly suitable for all types of cases

excluded. The statistics given below show that the standard of cleanliness in schoolchildren still leaves room for improvement.

Total number of examinations in schools by the School Nurse	27,328
Total number of individual pupils found to be infested	1,069

Handicapped Pupils.

There exists a lack of facilities in this area for the accommodation of school children who are found to be Educationally Subnormal. For almost the past year I have been carrying out special examinations on Educationally Subnormal children and have reported many cases as being in need of special educational treatment. So far as I am aware, no child has been so accommodated during the year. There seems little purpose in carrying out these examinations unless some definite action is to be taken. I am of the opinion that a special class should be opened in the Divisional area for the teaching of all children found to be classified as Educationally Subnormal and in Rawmarsh facilities have been offered by a headteacher who takes a special interest in such cases.

I would not like to close this part of the report without making reference to the high standards which have been maintained by Dr. M. R. Menzies, the Assistant School Medical Officer for the Division. She has shown herself to be keenly interested in her work and has proved to be an enthusiastic and agreeable colleague. Her relationship with the Divisional Staff, both nursing and clerical, is extremely cordial.

Section 57—Education Act (1944).

This Section of the Education Act has to do with the ascertainment and certification of school children who are found to be educationally sub-normal.

During the year the following number of children were submitted for examination under this Section of the Act :—

Number of children examined		31
Number of children found to be ineducable	5	
Number of children found to be educationally sub-normal	13	
Number of children merely dull and backward ..	9	
Number of children found to be maladjusted	2	
No recommendations made	2	

Child Guidance Clinic.

Schoolchildren who showed behaviour disorders and anti-social tendencies, or who were maladjusted, were referred to the Child Guidance Clinic conducted by Dr. M. MacTaggart at Barnsley. 7 cases were referred to this clinic during the year. These clinics are of great value in dealing with maladjusted children.

Report by the Assistant County Medical Officer—Dr. M. R. Menzies on Routine School Medical Inspections.

It was found impossible to complete the medical inspection of all 3 age groups during the year. After the Entrants and Leavers had been dealt with only half the number of children in the 2nd age group were examined.

Parents generally are very much interested in the inspection of younger children, but the independence of Leavers at the Secondary Modern Schools usually helps to determine the absence of indifferent if not busy mothers !

Most Headteachers are actively interested and co-operative, but the inadequate facilities for medical inspections at many schools must militate against their popularity, especially when a classroom has to be vacated for the purpose.

Infestation with Pediculosis Capitis.

This is a serious problem with only certain families who are indifferent and ignorant if not antagonistic in their attitude. There is persistent supervision and stimulation by the Health Visitors and School Nurses in the home as well as at school.

Clinics.

There was a year's waiting list for initial appointment at the E.N.T. Clinic before the sessions were reduced from 2 to 1 monthly. The appointment system and follow-up cards introduced for the School Clinics during the year have been particularly useful as a means of reviewing and grading cases awaiting E.N.T. appointments.

Sunlight.

The installation of a plant at Dunford House has considerably eased the pressure on the Rawmarsh Clinic.

Conclusion.

The report is as brief as compatible with covering the various aspects of the County Services. The Division is carrying out its duties efficiently. We feel the time has come to expand and develop. There is scope for such expansion especially in the Home Nursing Service, Health Education, Mental Health, After-Care and Prevention of Illness. I am much concerned with the lack of facilities for the accommodation of Educationally Sub-normal children.

In conclusion I would like to pay tribute to the clerical staff of the Divisional Office. Mr. J. Chambers, Senior Clerk, and Miss A. Watson are the only members remaining of our original numbers. The valuable help and assistance given to me by Mr. Chambers cannot be expressed in the cold print of this report ; whatever success this Division has had in the past two years is in no small measure due to his capabilities, enthusiasm and loyalty.

To the other members of the staff I can say that they have done well. All are interested in the Divisional Scheme. They have cheerfully and willingly carried out all their duties and our relationship has at all times been cordial and friendly.

The Central Staff at Wakefield have always been willing to advise and help us in all our difficulties and special tribute must be paid to the Medical Staff and their Senior Clerks for their interest in the progress of the Divisional Administration.

Appendix "A"

WEST RIDING COUNTY COUNCIL
PREVENTIVE MEDICAL SERVICES
Division No. 26.

Rawmarsh U.D.	18,650
Wath-upon-Dearne U.D.	13,660
Swinton U.D.	11,390

INFANT MORTALITY.

In 1948 there were 52 deaths in respect of infants under 1 year of age in the Division. 30 of these infants died in hospitals and the remaining 22 in their homes. The Infant Mortality rates for the different Districts were :—

Rawmarsh ..	64.86	(5 domiciliary and 19 Hospital = 24)
Swinton ..	44.3	(7 domiciliary and 4 Hospital = 11)
Wath	62.96	(10 domiciliary and 7 Hospital = 17)

The rate for the Division (i.e. the combined Urban Districts) was 58.5. This can be considered a high rate when compared with the rate of 34 for all England and Wales for the same year.

Disregarding for the time being the deaths which occurred in Hospital it might profit us to review the domiciliary deaths for the year 1948.

9 Infants died as a result of Prematurity—in one case the prematurity was associated with Broncho-Pneumonia and in another with Atelectasis. Prematurity may be due to a multiplicity of factors, some of which are within our control to prevent or at least to minimise. The first essential is thorough pre-natal care through the ante-natal care given to the expectant mother. A detailed check up on her general health in the early stages of pregnancy should include, not only the cardio-vascular and respiratory system but detailed investigation under the following headings :—

1. General nutritional state of the mother.
2. Haemoglobin estimation and blood count.
3. Rhesus determination.
4. Continuous urinary examination.
5. Continuous Blood Pressure recording.
6. Wasserman/Khan Test.

Each and every one of these factors is in itself important and may well decide the fate of the unborn child. Malnutrition of the mother—which may be due to innocent ignorance—will lead to defective foetal development and likely premature birth. This has been proved over and over again by surveys carried out by research teams. This then is one thing each and every one of us can deal with satisfactorily. Nutritional deficiency and Anaemia go hand in hand and it presents no great difficulty for us to ensure that mother receives a suitable food intake supplemented by issues of Iron, vitamins and milk. During her pre-natal visits, whether it be to surgery or clinic, or both, the nutritional factor should be constantly before our minds.

The prevention of Toxaemia to my mind is strictly within our control—I exclude only the form of Eclampsia described as fulminating and which is so rare as to be ignored in normal practice. One is apt to forget that the sequence of events in the development of Toxaemia is as follows :—

1. Rise above the normal limits of weight in pregnancy.
2. Rise in the Blood Pressure.
3. Oedema.
4. Albuminuria.
5. Eclampsia.

Regular weighing of the mother during the pre-natal care is therefore well worth while. If we pay due regard to the monthly increase in weight we can foresee the onset of toxaemia at an early stage. However, a close watch on the blood pressure will give us even more information. A woman who for example has a regular blood pressure reading of say 110/70 and then shows a reading of say 125/80 or so at a subsequent visit should immediately come under suspicion, and ordered to rest at home for a week or so and the blood pressure is again checked. If this has fallen we can relax our vigil a little but special attention should be given to the ante-natal supervision of that patient from that time onwards. If the blood pressure doesn't settle, more vigorous treatment should be given and the question of admitting to a pre-natal ward of a maternity unit should arise. By paying due regard to both the above points few women need reach the stage of oedema and almost none the stage of albuminuria or eclampsia. In my experience doctors are reluctant to "annoy" hospitals with requests to admit relatively mild cases of Toxaemia, but I feel that with the greater understanding of modern medicine that we should abandon this reluctance. Surely it would be better to provide ante-natal beds in order to prevent premature and still births than to facilitate admission to maternity units for normal confinements. You can be assured that this department will give you every help in its power in trying to obtain admission to Hospital for such cases. No doubt many mothers would be averse to going to hospital but in my own experience if the position is explained to them they usually agree. Such cases qualify for the services of a Home Help to look after the children and home during the patient's sojourn in hospital ; or indeed if the patient is confined to bed in her own home, under these circumstances a home help will be available. So much for the ante-natal

care. The intra-partum aspect may not be so simple. If due to constitutional disease, placenta praevia, etc., a mother is found to be in premature labour every endeavour should be made to have her admitted before parturition, to a nearby maternity unit. This in itself may save many an infant life and at the same time ensure adequate cover for the mother's well being. If this cannot be arranged then arrangements should be immediately made for the reception and care of the Premature baby. The Sorrento Cot with its special equipment including oxygen apparatus, etc., should be immediately requisitioned from the Divisional Health Office (The procedure is simple : ask the midwife to ring Wath 315/6 and give the telephonist at the Ambulance Depot the name and address of the case.) The midwife will inform the Divisional Medical Officer of the case and arrangements will be made for a midwife (specially trained in Premature baby care at the Sorrento Hospital, Birmingham) to take over the day to day care of the Premature baby under the practitioner's supervision. You are reminded that the services of Dr. C. C. Harvey, Paediatrician, are also available to assist you in giving succour to the infant. His telephone number for emergency is Doncaster 55343 and if not urgent, arrangements will be made through this office for Dr. Harvey to visit the case with the practitioner. If we co-operate in this scheme it is reasonable to suppose that a higher percentage of our prematures will survive, but in any case we will have cause to reflect that we have attempted to bring that end about. Experience has shown that domiciliary schemes for the care of premature babies can be highly successful in end results and I feel that we who live in a highly industrialised area have a glorious opportunity of confirming this opinion.

Erythroblastosis.

The significance of Rhesus factor investigation lies in the fact that when a baby is born of a Rhesus negative mother whose blood contains Anti-bodies, and subsequently develops anaemia and icterus, we are in a position to assume that the infant needs special transfusion to save its life. It will in fact mean transfusion with Rhesus negative blood which does not contain anti-Rhesus anti-bodies. Rhesus investigation has now become intelligible only to Haematologists but we can at least apply the clinical principles and these necessitate our investigation of the presence or absence of the factor in the expectant mother's blood. It is extremely important also from the mother's point of view—especially nowadays when Blood Transfusion has become almost routine procedure in moderately severe Post Partum Haemorrhage. Ignorance of the fact that anti-Rhesus anti-bodies are circulating in the mother's blood may lead to "Transfusion accident" and death.

In summary, therefore, we see that we have the means at our disposal to control to some extent the factors which govern premature birth and we have the means available to cope with prematurity when it does occur in domiciliary practice :—

1. Thorough Pre-natal supervision and investigation.
2. Using the facilities and special equipment available to bring succour to the premature in its own home.

Gastro-Enteritis.

4 Babies died at home from Gastro-Enteritis.
7 Babies died in Hospitals from Gastro-Enteritis.

The aetiology and classification of Gastro-enteritis is a complex subject. The ages of the infants at death are given below :—

1 week	3
3 weeks	1
1 month	2
5 weeks	1
3 months	1
5 „	1
6 „	1
7 „	1

Gastro-enteritis is described as an infection of acute onset characterised by intestinal derangement leading to Diarrhoea and commonly accompanied by vomiting. It is almost impossible to separate the causative factors responsible for the disease. However, we can say that any case of Gastro-enteritis will fall into one of the following categories :—

1. Dyspeptic—non-infectious.
2. Infectious—e.g. caused by the Typhoid-coli group of organisms ; salmonella, etc.
3. Enteral infections of unknown origin—possibly virus.
4. Parenteral infections—i.e. enteritis resulting from attacks of acute mastoiditis, apical Pneumonia, Pyelitis, etc.

Infantile immunity is unknown. Outbreaks occur in maternity units of Hospitals but by and large the greatest period of susceptibility is between the ages of 3 and 12 months. *Almost all babies who are exclusively breast fed escape the disease.* It is important to note that word "exclusively"—because many new born babies are often subjected to "mixed feeding." Breast milk is best for babies—it is the natural food, suitably constituted to the infants gastro intestinal tract ; it is bacteriologically pure and at optimum temperature. The disease is commonest amongst the ill-housed, overcrowded and less fortunate members of our communities. The disease manifests itself as Diarrhoea and vomiting leading to dehydration. Diarrhoea is the constant feature. When vomiting accompanies it the outlook is more serious. Dehydration can ensue rapidly and due to electrolytic changes in the blood stream may become irreversible—leading to death. The important thing, therefore, in all cases is to institute *rigorous* treatment *ab initio.* This will mean a careful check being kept on the fluid intake and at the same time ensuring that the nutritional demands of the child are satisfied. This will often require intravenous or subcutaneous technique. The greatest single factor in combating the disease is rigorous early treatment —not delaying active treatment until the child shows signs of worsening. The simplest method of fluid replacement is by giving half strength saline by mouth or better still Ringers or Hartmann Solution with or without 5% Glucose. Even in cases of moderate dehydration the subcutaneous route should be considered. A recent advance in the

technique of the subcutaneious route is the appearance on the market of Hyaluronidase.

The local injection of this into the skin facilitates the absorption of fluids. It is used nowadays in all units where Gastro-enteritis is treated. To prevent infant deaths from Gastro-enteritis, therefore, the following factors are important :—

1. Encourage total breast feeding.
2. Institute rigorous treatment early.
3. Make full use of Paediatric services.
4. Make full use of L.H.A. services—the Health Visitor for teaching the mother the Hygiene of infant care and the Home Nurse for supervising the medical care instituted by the family doctor.
5. Full use of the anti-biotic group of drugs.
6. Admission to Hospital of cases showing moderate dehydration.

Broncho-Pneumonia.

6 children died at home from Broncho-Pneumonia.
5 children died in Hospitals from Broncho-Pneumonia.

The ages varied from 2 weeks to 12 months. Most deaths were in infants between 2 and 4 months. Deaths from this cause are tragic incidents in the annals of infant mortality. Every case of measles should be watched carefully for the onset of respiratory trouble. The Sorrento Cots if available, will be issued on request for any child suffering from Pneumonia symptoms. Oxygen will be available as will also the services of the Home Nurses—who will act under the supervision of the family doctor. Arrangements will be made for the admission of cases of Pneumonia in infants to neighbouring isolation Hospitals—where the special treatment facilities are available. Such facilities include anti-biotic drugs, oxygen tents, skilled nursing and hour to hour medical supervision.

1949.

In dealing with 1949 the statistics for Infant Mortality show what standards can be reached. The Infant Mortality rates for the 3 Urban Districts of the Division were :—

Rawmarsh	..	26.94 in respect of 9 deaths	(2 Domiciliary)
Swinton	..	25.97 in respect of 6 deaths	(2 ,,)
Wath ..	..	60.48 in respect of 15 deaths	(11 ,,)

In the aggregate 30 infants died during 1949 in the Divisional area as compared with 52 in 1948. I feel that the ages and causes of death would be of interest and have, therefore, taken the liberty of giving them as an appendix. There were 828 live births in the Division during the year and I give below the numbers who were confined at home and the numbers confined in Hospitals.

Rawmarsh	172	Domiciliary	166	Hospital	Total 338
Swinton	154	,,	81	,,	,, 235
Wath-upon-Dearne	171	,,	84	,,	,, 255
	497		331		828*

* 828 live births were notified by the midwives and hospitals serving this Division. Of these, only 813 live births were assigned as

registered by the Registrar-General and the Infant Mortality Rates are based on the latter figure.

Certain of the deaths can be put as being due to causes outside our control and until more is known about the factors which influence pre-natal life there is little we can do. Rubella or sudden Pyrexial conditions in the expectant mother are held to be responsible for some developmental foetal arrest—leading to Anencephaly, Hydrocephaly, etc., but one cannot be dogmatic about this.

Of the domiciliary deaths Nos. 1, 4, 9 and 15 can be reckoned as being outside our control. The incidence of death from Broncho-Pneumonia is relatively high, Nos. 3, 5, 6, 7, 10 and 14, and is the greatest single cause of death in the Division of infants under one year.

Summary.

An attempt has been made to focus attention on the factors which influence infant mortality rate in the Division. Brief mention is made of the facilities available and the machinery which exists to ensure adequate cover for all sick infants—including the use of special equipment, Paediatric Consultant and home nurses and health visitors. These services are available to all Practitioners through the Local Health Authority and the Regional Hospital Board. It is suggested that full use of these services will often swing the balance in favour of a sick child and will eventually tend to reduce the number of infant deaths. In the background the Health Visitors and Clinic Welfare Officers will carry out Health Education by imparting to all mothers the essentials of baby care and Hygiene.

The Scheme will depend on complete unity existing between all sections of the medical and nursing profession working in the various branches of the National Health Service Scheme.

Domiciliary Infant Deaths.

Rawmarsh	1.	1 month	(*a*)	Convulsions.
			(*b*)	Spina Bifida.
	2.	1 month	(*a*)	Marasmus.
Swinton	3.	3 months	(*a*)	Broncho-Pneumonia.
	4.	3 days	(*a*)	Congenital Heart.
Wath	5.	7 months	(*a*)	Broncho-Pneumonia.
			(*b*)	Pink's Disease.
	6.	6 months	(*a*)	Broncho-Pneumonia.
	7.	6 months	(*a*)	Broncho-Pneumonia.
	8.	5 months	(*a*)	Convulsions.
			(*b*)	Broncho-Pneumonia.
			(*c*)	Gastro-Enteritis.
	9.	1 week	(*a*)	Congenital imperforate anus and recto-vesical fistula.
	10.	10 months	(*a*)	Broncho-Pneumonia.
	11.	5 months	(*a*)	Acute Gastritis.
	12.	1 day	(*a*)	Congenital alcholuric jaundice.
	13.	2 months	(*a*)	Gastro-Enteritis.
	14.	4 months	(*a*)	Broncho-Pneumonia.
	15.	2 months	(*a*)	Asphyxia due to obstruction of external orifices.

Hospital Infant Deaths.

Rawmarsh	1.	1 hour	(*a*)	Prematurity.
	2.	7 months	(*a*)	Cardiac Failure.
			(*b*)	Meningitis.
			(*c*)	Suppurative Otitis Media.
	3.	2 days	(*a*)	Prematurity.
	4.	10 months	(*a*)	Congenital Hydrocephalus.
	5.	4 months	(*a*)	Gastro-Enteritis.
	6.	2 months	(*a*)	Gastro-Enteritis.
	7.	1 day	(*a*)	Asthenia.
			(*b*)	Prematurity.
Swinton	8.	1 day	(*a*)	Atelectasis.
	9.	1 day	(*a*)	Melaena neonatorum.
			(*b*)	Haemolytic disease.
	10.	12 hours	(*a*)	Atelectasis.
			(*b*)	Prematurity.
	11.	1 day	(*a*)	Prematurity.
Wath	12.	6 days	(*a*)	Broncho-Pneumonia.
	13.	3 days	(*a*)	Surgical repair of oesophageal atresia.
	14.	12 hours	(*a*)	Atelectasis.
	15.	2 days	(*a*)	Erythroblastosis foetalis.

Domiciliary Midwifery Service.

In dealing with infant mortality mention should be made of the flying squad facilities available for obstetric emergencies on the District. Difficult confinement portends high risks to the infant, e.g. Disproportion, breech delivery, shoulder presentation, or any other cause of Dystocia. Much depends, therefore, on full cover being available for (i) The mother, and (ii) The child. Two teams should be available for difficult Domiciliary confinements :—

1. The Obstetric team for the mother.
2. The Resuscitation team for the infant.

Any arbitrary arrangements can be made, e.g. Obstetrician and Midwife for mother ; Practitioner for infant.

When delivery is effected the services of the Paediatrician can be obtained if desired.

The Flying Squad for this area is based on Moorgate General Hospital. The telephone No. is Rotherham 5141.

During 1949 there was no flying squad unit operating from the Montagu Hospital, Mexborough.